Care Quality Commission

Select Health Care Limited

Woodcote Hall

Inspection report

Nr Woodcote
Telford
TF10 9BW
Tel: 01952 691383
Website: www.selecthealthcaregroup.com

Date of inspection visit: 8 to 9 December 2014
Date of publication: 09/04/2015

Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection took place over two days on 8 and 9 December 2014. The inspection was unannounced. At our last inspection in August 2014, the home was meeting all but one of the regulations inspected. We saw improvements had been made with regard to this.

Woodcote Hall provides accommodation, nursing and personal care for up to 56 older people with a range of needs. There were 38 people living in the home at the time of the inspection. There was no registered manager in post. 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.

We found some beaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We also found a breach in Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

Everyone we spoke with told us more staff were needed. People considered the service was not always responsive

Summary of findings

to their individual needs due to staffing levels. We observed there was a lack of regular supervision for people seated in the communal areas of the home and for the people who remained in their own rooms. There were delays in staff responding to call bells. This meant that people were kept waiting for their care needs to be met.

People did not always receive the care they needed to minimise the risk of skin damage. They were not being mobilised when they needed to be and their dressings were not being changed at the assessed frequency. This meant they were at risk of harm.

Staff had received training to keep people safe and knew their responsibility to protect people from harm or potential abuse. However, the staff did not always demonstrate this in the care and support they provided to people.

We saw the service worked with healthcare professionals to make sure there was continuity of care to meeting people's needs. Most people received their medicines as prescribed with the exception of some creams.

We observed some people engaged for short periods in one-to-one activities with the activities organiser. However, most people seated in communal areas and in their own rooms lacked any social interaction.

Since our last inspection people had experienced further changes in the staffing and management arrangements of the home. This impacted on the quality of the service and the consistency of care that people had received.

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?

Inadequate

The service was not safe.

Three people required action to improve their care experiences. The service failed to effectively monitor their health needs.

There were not enough staff available to provide the support people needed. Turnover of staff had been high sometimes impacting on the consistency of the care people received.

Staff were appointed after suitable pre employment checks had taken place. Staff had received training to meet the needs of the people living at the home and to keep them safe. However, we found that in practice this was not always carried out.

Medicines were given as prescribed with the exception of people's creams. Medicines were stored following guidance with the exception of people's creams.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not have guidance to consistently support a person restricted of their liberty.

Staff did not receive regular supervision and annual personal development reviews to develop and motivate them and review their practice and behaviours.

Not all people experienced positive outcomes regarding their health.

People were given enough to eat and drink and assisted where they needed it.

Is the service caring?

Requires Improvement

The service was not always caring.

People felt they were treated with respect and their independence, privacy and dignity was promoted, although we did not always observe this. People felt that staff were task focused and did not sit and talk with them.

Not all staff were knowledgeable about people's individual care and support needs and this led to people not receiving care and support as their care plans stated.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were kept waiting for their care.

Summary of findings

People lacked social interaction and were not always at the centre of their care because staff focused on task, rather than them as individuals.

Most care records we looked at were personalised but lacked evidence of people's involvement of planning for their care.

Is the service well-led?

Requires Improvement

The service was not well led.

People had experienced further changes in the staffing and management arrangements of the home. This impacted on the quality of the service and the consistency of care that people had received.

The provider's quality assurance systems had failed to identify the shortfalls that we found at this inspection. Their systems had not been effective in identifying poor pressure ulcer management care, staffing and ineffective quality monitoring systems.

Woodcote Hall

Detailed findings

Background to this inspection

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

The inspection took place over two days on 8 and 9 December 2014 and was unannounced.

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 care service. Their area of expertise was in residential care.

Before our inspection we reviewed the information we held about the home and looked at the information the provider had sent us. We looked at statutory notifications we had been sent by the provider. A statutory notification is information about important events which the provider is required to send us by law. We also sought information and views from the local authority and other external agencies about the quality of the service provided. We used this information to help us plan our inspection of the home.

During our inspection we spoke with 27 people who lived at the home. We also spoke with five visiting relatives, 12 staff, the acting manager, two area managers and the director of operations. We looked in detail at the care five people received, carried out observations across the home and reviewed records relating to people's care. We also looked at medicine records and records relating to the management of the home.

During our inspection we used the Short Observational Framework for Inspection (SOFI) observation. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

We looked at how the provider managed risks to individuals for example, how they looked after people who had been identified as being at risk of their skin breaking down. We saw two people had not received their care as specified in their individual care plans which put them at risk of harm. For example, people had not been turned at the required frequency in accordance with their assessed needs. People had not had their pressure ulcer dressings changed in accordance with their care plan. This meant that these people were not protected against further risk of skin damage because staff were not following their care plans.

The short term care plan for one person stated that their dressings required changing daily. The daily log we looked at did not evidence this had taken place. The nurse on duty told us they thought the dressing required changing every three days. They confirmed they had not dressed the ulcer since the person was admitted to the home and thought they had a grade 4 pressure ulcer. This showed the nurse on duty lacked an understanding of the person's wound management requirements. The acting manager acknowledged that staff had not changed the person's dressing at the required frequency as identified in their records and that staff did not know how often the dressing should be changed.

We looked at one person's moving and handling care plan. This stated the person required two to three staff for repositioning, a hoist and a large slide sheet. An entry recorded in the person's daily notes stated, "Three staff used for safety reasons to reposition. Use a slide sheet". We spoke with a nurse on duty and a care worker who told us they found it physically difficult to reposition the person. The moving and handling risk assessment had not been updated to reflect the individual's preferences in relation to not using the hoist. The person told us that staff did not use the slide sheet as directed in the moving and handling risk assessment but always used the standard sheet on their bed. This was confirmed in discussions held with two care workers and the acting manager. We were told staff had used the slide sheet. This was confirmed by the person living at the home later that day.

We spoke with the operations director about our findings with regard to people's pressure area management. They could not offer us any explanation as to why the management of some people's pressure ulcers was so poor. We told the provider to make a referral to the local authority safeguarding team for this person in addition to two other people for potential neglect.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of this report.

People who lived in the home told us the staff did their best but there were not enough of them and staff did not have enough time to support them when they needed assistance. One person told us, "They are always in a rush". One person said, "There's never any staff around and they are always too busy to help you". A visitor shared their concerns with us in relation to the length of time a person had waited for a member of staff to attend to their personal care needs. Four visitors raised concerns about staffing levels. One visitor told us that someone had also waited so long for a care worker that their dignity was not maintained.

We observed people seated in communal areas were left for long periods of time unsupervised. These were people who required assistance from staff to meet aspects of their needs. There was no call bell in the main lounge for people to use if they wanted to summon assistance. We were told there was no need for a call bell as the office was close by and staff were always popping in and out. This was not observed during our inspection which put people at risk from not receiving timely care. There was also a lack of regular supervision for the people who remained in their own rooms. There were significant delays in responding to call bells that were constantly ringing and caused distress to people who were seated near to the door in the main lounge area. We spoke with staff about the staffing levels. One member of staff said, "There just aren't enough staff. This morning another care worker came to me requesting assistance with someone who required two people but I was in the middle of helping someone else". They went on to say, "As much as you want to respond to bells, you just can't drop everything". Another staff member told us, "There are not enough staff throughout the day. It's hard work. New staff see how hard it is and then leave".

Inadequate

Is the service safe?

The turnover of staff had impacted on the consistency of care people received. This was because there had been a number of agency staff used to cover vacancies and these staff did not consistently know the people who lived at the home in a way that permanent staff knew them.

We asked the area manager how staffing levels had been calculated for the needs of the people who lived at the home. They told us that a dependency level assessment had recently been carried out and the staffing levels were established on this assessment. However, based on our findings managers agreed to review staffing levels as a matter of urgency.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Concerns were shared with us about people not having their personal care needs met in a timely manner. We observed this during our inspection. One person told us they required assistance from care workers to use the toilet. They told us, "I am often kept waiting for the staff to assist me onto the toilet. I am often incontinent of urine due to the delay in carer workers getting to me". Another person we spoke with in the afternoon told us they had not been attended to since the early hours of the morning. We spoke with staff and they confirmed that this person had not been attended to due to the shortage of staff. Care records we looked at relating to this person reflected this.

Seven people we spoke with said they felt safe living at the home. Staff we spoke with confirmed they had received training in protecting people from harm and gave examples of what constituted abuse. They were aware of the policy and procedure to speak out if they observed any poor care practice. However, two staff commented that they had never seen the policy. One nurse we spoke with told us they did not know how to report an allegation of abuse. They told us they would have to telephone a senior manager for advice. This meant that if the nurse was alone in charge of the home they did not confidently know the procedure for making a referral to the local authority safeguarding adult's team. The local authority lead on investigations when an allegation of abuse has been made. We asked nurse and a senior care worker where the safeguarding policy was held. This could not be located at the time of our inspection. The acting manager asked the administrator to supply copies of all the procedures that could not be located during our inspection. Since the previous inspection there had been one person appropriately referred into the local authority safeguarding adults process. Our records showed the provider had notified us about the safeguarding incident as required.

We looked at how the home managed risks in relation to people's care. We saw that risk assessments had usually been completed for things such as use of bed rails, pressure ulcers, diabetes, falls and moving and handling. We saw that individual dependency assessments and nutritional assessments had been completed and reviewed. One care plan we looked at had not been completed for safety and vulnerability. This meant staff did not have all the information about this person that they needed to support them and maintain their safety. We found the person had not been repositioned at the assessed frequency. We spoke with staff about this. They knew the person required repositioning every four hours but told us they did not have time to do this because of the insufficient staffing levels and the high needs of the people they cared for. This lack of care could have led to the person's skin deteriorating further.

We spoke with a member of staff about how they were recruited to the home. They told us that the process was rigorous and said, "I couldn't start before all my checks were completed". We saw evidence of this in the staff files we reviewed. We saw the provider followed a recruitment process that ensured new staff were checked before they started employment at the home.

We spoke with people about their medicines. One person told us they had waited over an hour for their pain killers. They said this was not the first time they had waited for their medicines. They were able to provide dates and times of when this had occurred. We found a member of staff to get their medication and this was dealt with promptly. Another person told us, "Medication is often late due to pressure on staff". We observed people being given their medicine. People were supported and encouraged to take their medicines. We found two people were not always getting their creams as prescribed by their doctor. For example, creams and ointments were found left in people's rooms for care workers to apply. These were not being consistently applied as confirmed by people who lived at the home and the care workers we spoke with. Records showed these were not being applied at the required frequency.

Requires Improvement

Is the service effective?

Our findings

Most of the people we spoke with considered staff were knowledgeable about their individual needs and preferences. One person said, "The carers know me well". A visitor told us that the staff were, "Very good" and another said, "Staff would do anything for you".

Care workers told us they had received an introduction to their work. One care worker said, "I was teamed up with someone with experience. Induction was definitely helpful and opened my eyes". Care workers told us they had completed essential training and they had completed a workbook which was overseen by the management team. Staff felt they had the skills and knowledge they needed to meet people's individual needs. However, they felt there was a lack of formal support arrangements in place. For example, two staff told us they had not had one-to-one meetings with a manager for over twelve months to discuss their practice and development needs. We were assured by the Director of Operations that the issue would be dealt with as a matter of urgency.

We looked at how the home protected people's rights. We also looked at Deprivation of Liberty Safeguards (DoLS). DoLS aims to make sure people receiving care are looked after in a way that does not inappropriately restrict their freedom. We were told that an application had been made to the local authority for one person who they considered was deprived of their liberty. The area manager was knowledgeable and knew their role and responsibility required of the legislation. However, we found no care plan was in place to guide care staff on how to support this person in relation to the restriction of their liberty. Two care workers we spoke with were able to tell us how they supported the person but there was no recorded documentation available on their care records to ensure the person received consistent and effective support. Following our inspection the acting manager confirmed that this had since been addressed.

We spoke with people about the food. One person told us, "The food is quite good". Another person said, "The food is not good here". One person said, "Pasta, pasta, pasta and I don't like pasta". We observed the lunchtime meal and saw that the tables had been laid before people arrived for lunch. However, there were no condiments for people to use if they wanted to. There was no indication of what the menu consisted of or menu cards on the tables to remind people of the choices available. People we spoke with were not aware of the food choices available on the days of our inspection. People that required specialist equipment to maintain their independence were provided with appropriate aids. This meant that they could eat independently. Some people chose to eat lunch in their bedrooms and care workers enabled them to do this. People were given a choice of meals and refreshments. Lunchtime was relaxed with care workers discreetly assisting people that required support with eating. We met with the chef who told us menus were about to be introduced in the home. We discussed the feedback we had been given with the chef. They were aware about the pasta comments and had noted this for when the stock of pasta had been used up. The chef told us about the special diets they prepared at the home. They were aware of people's individual requirements and preferences and told us what action they would take if a person had been identified as being at risk of malnutrition. Records checked showed people's weight had been monitored regularly which helped ensure they maintained a healthy weight. One nurse told us they involved doctors, dieticians and speech and language therapists if any concerns were raised about a person not eating their food.

The provider had not completed a health and medical needs care plan for a person which related to their diabetes. Their nutritional care plan identified that the person was diabetic but failed to include how to support this specific need. This meant staff did not have the information to maintain the person's safety and to manage their individual needs. We spoke to the person about their diabetes they told us, "Sometimes staff forget that I'm diabetic and put sugar in my tea". This was confirmed by a care worker. One care worker we spoke with did not know the person was diabetic and told us staff had been giving them drinks with sugar. This meant the person was at risk of receiving inappropriate support to manage their diabetes.

People said they could see a doctor when they needed to. However, a visitor to the home told us they did not think their relative's health needs were being met. They told us about an incident that they had raised with staff at the home during our inspection. We discussed this later with the acting manager who addressed this. They confirmed the person's care records had been updated to reflect the concerns and staff were made aware of the need to be aware of the issues raised. We saw that this had been done

Requires Improvement

Is the service effective?

when we looked at their care records. We saw evidence that people had access to health care professionals including doctors, chiropodists and tissue viability nurses.

Records of professional's visits were recorded in the care records that we looked at. This meant people could access the services of health care professionals when they needed to.

Requires Improvement

Is the service caring?

Our findings

One person who lived at the home told us, “The staff are kind and caring”. Another person said, “They don’t listen to you. “I asked a carer to do something for me but I had no response, they just walked off and didn’t return”. People told us there were no restrictions on when their visitors could see them. One person told us, “My family come and go as they please”.

We observed care workers were kind and showed compassion to people who lived at the home. However, they had no time to spend with people engaging in any meaningful conversation except when tasks were being carried out. For example, serving lunch, serving refreshments and when people received personal care from care workers.

People did not have choice and control over everyday decisions for example they could not use the toilet when they wished because of staffing shortages. They waited for their care and support to ‘fit in’ with when staff could attend and support them. We observed people were placed in chairs for long periods without a change of position or being asked if they wanted to sit elsewhere. This did not promote people’s choice or independence. In the reception area of the home there was a range of information available for people in a way that was accessible. This included information about advocacy. Advocacy is a process of supporting and enabling people to express their views and concerns, access information and services, defend and promote their rights and responsibilities and explore choices and options.

One person told us, “Staff do respect my privacy and dignity”. Another person said, “The staff knock my door before they come into my bedroom”. Staff were able to give examples of how they promoted people’s dignity. For example one member of staff told us they always knocked on people’s doors and ensured they maintained people’s dignity during personal care. However, our observations and findings did not always show that people were treated with respect, dignity and were listened to. For example we identified that people were left for long periods of time and were not supported with their personal care in a timely manner. We were also made aware during our inspection that people had their dignity compromised whilst waiting for staff assistance.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with felt they had contributed to the assessment and planning of their care but some people considered the service was not always responsive to their individual needs for example people told us they had to wait for help. We found care workers did not always know people and this was demonstrated by staff who did not know someone was a diabetic or people's personal care regimes.

People who used the service or their relatives were involved in expressing their wishes with regard to their care needs. One person told us, the area manager had visited them at home to discuss and assess their care needs before they moved into the home. They said they felt involved in their care and chose to remain in bed, which the staff respected.

People told us they had enjoyed the Halloween and bonfire party held at the home. One person said, "We had a good time together". We saw some people chatted with the activities co-ordinator and some individual's enjoyed having a manicure. Some people chose to watch television during our inspection. One person completed a jigsaw with members of their family. We saw some people who were alone in their rooms did not receive any social stimulation. There were not always enough staff available to support people to follow their day to day interests and take part in social activities.

People told us they had not raised any concerns but said if they had concerns they would speak to the staff. We saw the provider had a formal procedure for receiving and handling complaints. A copy of this was displayed in the home's reception area. There was also a suggestion box available although some people commented they did not know it was there. The area manager said that they had not received any complaints since the last inspection. Although no complaints had been received, staff we spoke with were aware of the procedure to follow if someone raised a complaint.

Requires Improvement

Is the service well-led?

Our findings

The home does not have a registered manager in post. We were notified the previous registered manager left in August 2014. A replacement manager was appointed but left before registering with CQC. At this inspection we met the acting manager who had recently been appointed. One member of staff told us, "There have been lots of changes here for the better; the care workers have all been appointed. New staff are better supported". Although the acting manager had only been working at the home for approximately two weeks, staff we spoke with were positive about them and how the service was led by them and the area manager. One member of staff said, "[name of acting manager] has been great and will work on the floor and assist us with people". Another member of staff told us, "[name of acting manager] is very approachable and you can ask them anything at any time".

People living and working in the home told us they had experienced significant changes in the staffing, management and leadership of the home. This has had impacted on the quality of the service and the consistency of care that people received. People had experienced inconsistent leadership and direction which the provider had previously acknowledged. Since our last inspection, people had again experienced further change because the former manager had terminated their employment. An acting manager had recently been appointed. They had completed an introduction to working at the home when they started their employment and were being supported by the area manager. However the area manager informed us they were terminating their employment at the end of December 2014. We discussed our concerns about the management of the home and support for the acting manager with the operations director. They told us that the manager vacancy would be advertised and a new manager would be appointed as soon as possible. In the meantime the acting manager would stay in post until a manager was appointed. We were told the acting manager would be supported by the operations director and company director in the interim.

People who lived at the home told us residents' meetings took place but no action had ever been taken following these meetings. The last meeting was held September 2014. The minutes for this meeting were not available as the previous manager had left and had not typed the minutes up. This meant people did not have access to the information discussed. Five people who lived at the home told us they had given up on any changes or suggestions ever being taken into account. For example, they had raised on a number of occasions that they did not like the amount of pasta dishes being served at the home and this had not been addressed. We saw pasta was served on the day of our inspection. We were told by the area manager that the last staff meeting was held on the 6 November 2014 to inform staff of the changes to the management of the home.

The provider shared with us new audits that had been introduced since our last inspection. We found that not all of these were effective. For example, the last skin integrity audit had been carried out in October 2014. This audit was ineffective and failed to identify the issues we found at this inspection. The audit had not been reviewed by the area manager. Therefore the provider had not carried out their own checks to ensure the service was operating in a way that ensured people were safe and received a good standard of care and support. We found the systems in place to monitor and evaluate the quality of the home were ineffective and had a serious impact for people who lived at the home. For example people's health and wellbeing, people not receiving their creams and ointments as prescribed, staffing and gathering residents and relatives views were compromised by poor monitoring systems.

This issue was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010.

There were regular environmental checks in place to ensure the safety of the environment that people lived and worked in. We were informed that the environmental audit had identified that the treatment room required refurbishment. Plans for this work to be undertaken had been made. The acting manager told us they had been requested to look at the accident and incident records following their appointment. They told us they had not identified any concerns relating to trends and patterns of any incidents reported.

The provider sought to obtain people's views about the service by means of an annual survey. We were told that the next annual survey was due to take place in the New Year and the outcome of the survey would be published

Requires Improvement

Is the service well-led?

and made available for people. However, people who we spoke with told us, they had never completed a survey and would welcome the opportunity because they had some suggestions to make.

The provider had not submitted appropriate notifications to the Care Quality Commission as required by regulation about incidents which affected people's welfare, safety or health that may have needed acting upon if necessary. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of this report.

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 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People who use services were not protected against the risks of receiving care or treatment that is inappropriate or unsafe Regulation 9 1(a)(b) (i)(ii).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **Systems to regularly assess and monitor the quality of the services provided were ineffective.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **People's health, safety and welfare was not safeguarded because the provider had not taken appropriate steps to ensure that at all times there are sufficient numbers of suitably qualified, skilled and experienced persons employed to meet people's needs.**