Care Quality Commission

Woodfields Residential Carehome

Woodfields Residential Home

Inspection report

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Ratings

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

Overall summary

We undertook an unannounced inspection of Woodfields Residential Home on 28 January, and 3 and 4 February 2015. We last inspected the service on 15 October 2014 to look at how the provider managed medicines. At our previous inspection the provider was not meeting the law in relation to the safe management of medicines. Following our October 2015 inspection the provider sent us an action plan to tell us the improvements they were going to make.

At a previous inspection on 8 May 2013 the provider was not meeting the law in relation to the management of medicines and staffing. The provider sent us an action plan to tell us the improvements they were going to make in relation to these areas.

During this inspection we looked to see if these improvements had been made. We found that, while some areas had improved, further improvements were required.

Summary of findings

Prior to this inspection, we had received information of concern about one person was being cared for at the service. We looked at matters relating to these concerns during the inspection.

Woodfields Residential Home provides accommodation and personal care for up to 17 older people. At the time of our inspection 13 people were living at the service.

There was a registered manager in post at the time of our inspection. 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.

People were positive about the service they received. Most visitors were also positive about the service. One visitor raised issues which we referred to the local safeguarding authority.

Updated risk assessments were not consistently available in people's care records. Where available updated, accurate risk assessments gave guidance to staff on how to reduce risk or harm to people when undertaking certain activities or when specialist equipment is used during their care.

The provider had not applied consistently safe recruitment practices, by ensuring that checks were carried out to show staff were of good character before they started working at the service.

We found improvements in how medicines were managed. For example, records indicated that people received the medicines they required to promote their health. However, there was still a lack of robust guidance for staff about when to administer 'when required' medicines, such as pain relief.

Staffing levels had increased and people told us there were enough staff to care for them. However, we observed periods of time where people in communal areas were left unattended by staff. People did not have the facility, such as call bells, to call staff to these areas should they require assistance.

Staff we spoke with knew how to keep people safe, by reporting issues of concern in the appropriate way. Staff were provided with guidance about how best to evacuate people in an emergency.

Staff demonstrated a poor understanding of people's rights and how people were restricted. Staff gave inconsistent answers as to who was subject to restrictions in their liberties; for example, leaving the service unaccompanied. Care records showed a lack of mental capacity assessments and best interest decisions for people who staff said were not able to make certain decisions. This meant there was a risk people's rights would not be respected.

People told us they enjoyed the food on offer at the service. However, records relating to how much food and drink people had consumed were inconsistent and contradicted each other. The records of people who were at risk of dehydration sometimes showed low fluid intakes and this had not been identified by the provider. Staff were unaware of how much fluid some people required to maintain their health. Staff demonstrated that they were aware of people's special food requirements, such as soft diets.

People's health was supported by appointments with external healthcare professionals, such as doctors.

People told us staff were kind and caring. Staff supported people in a compassionate way and ensured they communicated with people in the way they preferred. Staff sought to understand people's choices and respected these. Staff promoted people's dignity, privacy and independence.

Care plans were not always personalised in respect of people's specific medical conditions. Staff were flexible in their approach to people's care if their health changed. People and relatives were involved in care planning and staff listened to their opinions. People said they would feel comfortable in raising issues with staff. The provider had an effective complaints process in place.

People, most visitors and staff we spoke with were positive about the management team at the service. Staff received support from the management team in carrying out their roles.

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

Summary of findings

correspond to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risk assessments were not always updated to reflect the latest risks to people.

Management of medicines had improved, but guidance in relation to 'when required' medicines were not robust enough.

Pre-recruitment staff checks were not always carried out to show staff were of good character. The manager did not have a clear understanding of the provisions around some checks.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff gave inconsistent responses concerning whether people's liberties were restricted. There was a lack of mental capacity assessments and best interest decisions to demonstrate people's rights were respected.

Fluid charts were inconsistent, which meant it was difficult to assess whether some people received the correct amount of fluids to support their health.

People's health needs were supported by appointments with external healthcare professionals.

Is the service caring?

Good

The service was caring.

Staff supported people in a kind and compassionate way.

Staff respected people choices and supported their decisions.

People's dignity, privacy and independence were promoted by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care planning were not always personalised to reflect how their specific health condition might affect their needs.

Staff were aware of and supported people's preferred daily routines.

Staff were flexible in their approach to people's care, when this was required.

Is the service well-led?

Requires Improvement

The service was not always well led.

People, most visitors and staff were positive about the management team at the service.

Summary of findings

There were some gaps in policy, procedure and the auditing of the quality of the service. This meant that shortfalls in the quality of the service were not always identified.

The manager had worked with an outside agency to improve infection control at the service.

Woodfields Residential 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, and to provide a rating for the home under the Care Act 2014.

This inspection took place on 28 January, 3 and 4 February 2015 and was unannounced. The inspection was carried out by an inspector and a pharmacy inspector.

We looked at the information we held about the service. This included statutory notifications, which are notifications the provider must send us to inform us of certain events. We also contacted the local authority and the local clinical commissioning group, who monitor and commission services, for information they held about the service.

During our inspection we spoke with four people who used the service, three relatives and a visiting professional. We also spoke with the registered manager and four care staff.

We reviewed the care records of four people who used the service, staff records and records relating to the management of the service.

We undertook general observations in communal areas. We used the Short Observation Framework for Inspection (SOFI) during lunchtime in the dining area. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

There were insufficient systems in place to keep people safe. We found inconsistencies in risk management and risk assessments. Risk assessments are designed to reduce risk to people when carrying out certain activities or aspects of care. We saw, from accident records, that one person had sustained a number of recent falls. We saw that risk assessments around them falling again had not been updated following any of these falls. This meant that strategies about how the risk to this person falling again could be reduced had not been considered. We spoke with the manager about this, who undertook to ensure an updated risk assessment was produced and shared with staff.

We saw, from accident records, that a person had reported banging their head and feeling unwell after this had happened. We could find no indication that appropriate procedures or medical assistance had been given as a result of this report. We asked the manager and a senior member of care staff about this incident. They were unable to tell us what action had been taken. There was no guidance available for staff to advise them on what to do if someone fell, such as what observations they should make or when they should seek medical assistance. This meant that there was a risk staff would not respond, and consider risk, in the way needed if someone fell or sustained a head injury.

These issues demonstrated a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us they had undergone appropriate checks prior to employment. We looked at two staff records. We found that appropriate checks, prior to staff recruitment, were not always carried out. One staff record showed that the provider had not carried out a new Disclosure and Barring Service (DBS) check. This is a check which shows if a person has been prosecuted for a crime. We spoke with the manager about this who said they had relied on the previous check carried out by a former employer of this staff member, which was on file. This check was carried out in December 2013. The manager told us that their understanding was that previous employer DBS checks could be relied upon, which was incorrect. The manager could also not demonstrate that they had confirmed the DBS status of agency staff, who were occasionally used by the service. They said they relied on the agency to do this. Our discussion showed that the manager was not aware of their responsibilities for carrying out DBS checks of prospective staff.

These issues demonstrated a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our previous inspection of 15 October 2014 we found that medicines were not always safely managed. We found that appropriate arrangements for the recording of medicines were not in place. People had not always received the medicines they needed to maintain their health. There was inadequate guidance for staff to understand when people might need 'when required' medicines, such as pain relief.

During this inspection we found that the management of medicines had improved since the last inspection. People we spoke with said their medicines were being managed in the way they wanted. We looked in detail at 10 medicine administration records and these indicated that people were receiving their medicines as prescribed by their doctor.

We looked at the disposal records for medicines that were no longer required by the service. The records showed that these unwanted medicines were being disposed of safely. We looked at the records for people who were having medicinal skin patches applied to their bodies. We found that these records were able to demonstrate that the skin patches were being applied safely.

Medicines were being stored securely, and at the correct temperatures, for the protection of people using the service. We observed some good administration practices taking place during the lunchtime medicines administration round. We saw that administration records were being signed before the medicines had been given, which was not good practice.

During our previous inspection of 8 May 2013 we found that the provider was not meeting the law in respect of staffing as there were not enough staff during the night to support people safely.

Requires Improvement

Is the service safe?

During this inspection people told us there were enough staff to assist them, when they required. One person said, "When I needed them, staff came immediately". Another person said, "I press the button and they come straight away". We saw that the staff to people ratio had increased since our inspection of 8 May 2013. During our previous inspection we found that staffing at night was inadequate and could present a risk should people need to be evacuated due to an emergency. During this inspection we found that less people required two staff in order to move, and there were fewer people living at the service. A fire officer had visited the service and confirmed that night-time staffing levels were appropriate for emergency evacuation purposes.

However, we found that a lounge, which was designated for people who required higher levels of support, was left unattended by staff for periods of time. The longest period we recorded was approximately 15 minutes. There was no provision for people to call staff in this lounge, such as accessible call bells. This meant that there was a risk people would not immediately be able to attract staff attention, when required. We also saw there were periods of time, during lunch, when staff were not available in the dining room. We looked at people's records and noted that one person eating in the dining room was at risk of choking. This meant that there were periods of time when this person was eating unsupervised by staff, when they may have required assistance. We spoke with the manager who agreed that there should have been staff present in the dining room to assist people if needed.

All people we spoke with told us they felt safe living at the service. One person said, "I'm safe here; [staff] are very kind". Another person told us, "Staff don't hurt me". All relatives, except one, also told us they felt people were safe living at the service. One relative told us about issues which led to us raising a safeguarding alert with the local authority. Local authorities are responsible for investigating matters where abuse, such as neglect, is alleged to have occurred.

We spoke with staff who demonstrated that they were able to identify different types of abuse. Staff told us they would report suspected abuse either to the manager, or if appropriate, to the local safeguarding authority or the Care Quality Commission. We saw that the service had a policy concerning keeping people safe which was accessible to staff and offered guidance on identifying and reporting abuse. There was also information about keeping people safe prominently displayed in a staff area.

We found that people had personal emergency evacuation plans in place. These provided guidance about how each person should be supported to evacuate the premises in the event of an emergency, such as a fire. This guidance was clearly displayed on each person's bedroom door. This meant that the provider had considered the needs of people, including those with sensory or physical challenges, in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

We spoke with staff about their understanding of Deprivations of Liberty Safeguards (DoLS). The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. The manager told us that no one living at the service was subject to a DoLS. The local authority confirmed that no applications for DoLS had been received from the service. We asked staff if anyone living at the service was subject to a restriction in their movements. Staff gave inconsistent answers and told us that some people were restricted, when they were not. They told us that, for example, they were able to prevent certain people from leaving the service unaccompanied. This meant that there was a risk some people would be prevented from exercising their choices.

Staff told us that some people living at the service lacked the capacity to make certain decisions. We looked at the records of people who were said to lack capacity. We saw examples of family members signing consents and other records to indicate agreement with aspects of people's care. However, records lacked capacity assessments. These are assessments which show that the person's ability to make decisions has been appropriately assessed. We also found there were no best interest decisions to show how certain decisions had been made in the person's interests and who was involved in the decision. The manager was unclear about what was needed in order to show proper consideration had been given to decisions made about people's care.

These issues demonstrated a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they were given plenty of fluids to drink. One person told us, "Oh yes. I'm on my third cup of tea this morning".

We looked at the fluid and food charts of three people who were at risk of dehydration and malnutrition. These showed how much people had to eat and drink. We found that what people had to drink was recorded on two different charts. These charts were inconsistent with each other. Some charts showed people who were at risk of dehydration had received low levels of fluids. These people could not tell us about how much they were given to drink throughout the day. We asked staff about how much one person was supposed to have to drink, but they were unable to tell us, and gave us inconsistent answers. This meant it was difficult to assess whether people received enough to drink in order to keep them healthy.

Staff we spoke with understood the importance of keeping people hydrated in order to promote their health although only a minority had undertaken formal training in this area.

People were positive about the food they received at the service. One person told us it was, "Five star. Very good food. Good choice". Another person told us, "There's plenty of food on offer. You can always ask for something else to eat". A third person said, "We can ask for something different. They got chicken Kiev in for me". We observed people eating lunch. Food was plentiful and looked appetising. People commented on how much they had enjoyed their lunch. We saw that one person required a soft diet, due to a risk of choking. We saw that this person received the food they needed. Some people commented about the fact that a staff member was vacuuming nearby, and this had affected their lunchtime experience. We raised this with the manager, who undertook to ensure mealtimes were not disturbed by staff cleaning.

Most people were positive about the service. One person told us, "The service is great". People we spoke with told us they felt staff were skilled in assisting them. We observed staff delivering care and using specialist equipment. We saw staff did this competently. Staff told us they received the training they needed in order to feel confident to deliver quality care. One staff member told us, "We do have enough training". Staff told us, and records confirmed that they had under gone an induction period where they were able to get to know the service and what was expected of them in their roles.

People we spoke with told us they saw a doctor or other professionals, when they required. Care records confirmed that people were supported to access external healthcare professionals in order to support their health and well-being. We saw that, where required, staff had supported referrals to specialist healthcare professionals. This included speech therapists and mental health

Requires Improvement

Is the service effective?

professionals. We spoke with a visiting professional who told us that staff were cooperative and applied the advice they gave, in order to support the person they were visiting in the way they needed.

Good

Is the service caring?

Our findings

Most people were positive about staff and described them as being kind and caring. One person told us, “All the staff are nice”. Another person said, “They’re all kind”.

We observed staff assisting people. We saw that staff acted with compassion and consideration while supporting people. Staff chatted to people throughout the day and people reacted positively to staff. For example, one person was assisted using a piece of specialist equipment. Staff who assisted them talked to them throughout the procedure. They gave assurances to the person and explained what they were doing. We looked at this person’s care records and saw that they sometimes became agitated and uncomfortable when assisted in this way. Staff followed the guidance in this person’s care records, for example, by communicating in the way the person preferred. The person remained calm while they were being supported in this way.

People told us that staff respected their decisions. One person told us, “[Staff] always ask what you want”. Staff we spoke with demonstrated a good understanding of people’s preferences and wishes. Staff accurately reflected how people preferred to be supported. We spoke with an external professional who had been working with a person living at the service. They told us that staff had implemented their recommended strategies in how they should best support the person without causing distress to them.

People we spoke with confirmed that there were offered choices about things such as activities and food. We observed staff offering people day to day choices, such as what they wanted to do or where they would prefer to eat lunch. We saw staff responding positively to people’s choices. Staff gave good examples of how they offered choice to people. People’s care records gave guidance on how people preferred to communicate so that staff could ensure they offered choice, and understood people’s preferences.

People told us staff respected their privacy, independence and dignity. One person told us, “I can lock my door from the inside if I want”. We observed staff respecting people privacy and dignity. For example, staff knocked on people’s bedroom doors before entering. Staff gave us good examples of how they protected people’s dignity during personal care. They described how they supported people to complete as much personal as they safely could for themselves. They told us this supported people’s dignity, but also promoted people’s independence.

Requires Improvement

Is the service responsive?

Our findings

Most people we spoke with were positive about the care given by the service. One person told us, "Very nice. Look after me very well".

We looked at the care records of people that had specific health care needs. We found that, where someone had a specific health condition, their records contained general information about the condition from the NHS website. However, there was a lack of personalised care planning concerning specific conditions, about what the condition meant for the person and how staff should consider this while supporting them.

We saw that one person was at risk of low fluid intake. Appropriate referrals had been made to external professionals as a result of this. However, this person's care records did not contain guidance around strategies for encouraging the person to drink more. Personalisation of care records, taking into consideration people's health needs, would ensure staff had access to information they need to care for people as they require.

Although people were being protected from developing sore skin, staff interventions were again not geared to individual needs and there was some confusion about how frequently people were being re-positioned. We asked someone, who was cared for in bed and who was at risk of sore skin, if they felt comfortable. They told us, "I'm very comfortable". We looked at the records of people who required regular repositioning due to the risk of their skin being sore. We spoke with the manager about how these people were supported. The manager told us people were repositioned hourly, and that this frequency of repositioning was the service's policy. This policy contradicted what some people's care plans said should happen. Staff we spoke with confirmed that they repositioned people hourly. This meant that some people were being repositioned more frequently than they required. This included repositioning throughout the night which would disturb their sleep, unnecessarily. We raised this with the manager who said they would seek advice from a specialist nurse to ensure people were being repositioned at the frequency they required to maintain healthy skin.

People told us that staff recognised their likes and dislikes. One person told us how they liked to be in their room at certain times of the day. They told us staff knew this and assisted them to be where they wanted to be. We asked staff about people's preferences and preferred daily routines. Staff demonstrated knowledge of people's likes and dislikes, such as their preferred time to get up. We observed staff respecting these preferences.

We saw that, where appropriate, people's care plans included flexibility for changes in health. For example, one person's care plan detailed how they should be assisted to move about. The care plan included guidance if the person was less well on certain days. We saw staff assisting this person in line with this guidance, as they were more tired on the day of our inspection. This meant that staff responded in a flexible way to people's needs.

Two visitors explained that staff would ring them if there were any concerns about, for example, health matters in respect of their relative. They told us staff appropriately consulted them about issues affecting care planning. Records confirmed that staff regularly communicated with people's representatives about issues which affected them. Records showed that care plans were regularly reviewed.

We asked people about what they liked to do and whether they were supported by staff to take part in their preferred hobbies. Two people told us that they enjoyed reading and that they were able to access books from the service or were facilitated to obtain books from the local library. No-one we spoke with told us they felt unoccupied or bored living at the service. One person told us the service organised special events throughout the year. They said, "At Christmas we had an entertainer, a proper Christmas dinner and presents". They also told us, "I never get bored".

People we spoke with told us they would feel comfortable in raising issues with staff. One person told us, "I'd speak to the manager. He's quite approachable". We spoke with two visitors to the service who told us they had spoken with staff about minor issues and that staff had responded appropriately to these. No-one living at the service said they had cause to make a complaint. One person told us, "No complaints; very happy here". We saw that the provider had a complaints procedure and that this was advertised in the entrance hall. The procedure was also explained in a service user guide, which was given to people for information about the service. This meant that people

Requires Improvement

Is the service responsive?

would know how to raise matters of concern. We saw that the provider kept an appropriate log of issues raised and how they had been dealt with in line with the complaints procedure.

Requires Improvement

Is the service well-led?

Our findings

Most people told us they were happy with the service. Two visitors told us how they chose the service through a personal recommendation from someone with experience of the service. People told us that the management team were approachable. One person said, "I can speak to [senior staff member]. She's a nice lady". People also described the manager as approachable.

Staff were positive about the management team and the support they received from them. We found that staff received regular one to one meetings with supervisors. Staff told us they were able to raise any issues or discuss additional training they would like to participate in during these meetings and their annual appraisal process. Staff told us, and records confirmed, that staff attended staff group meetings where issues which were important to people were discussed, such as their changing needs.

There were some systems in place to measure and address quality of care, but they were not always effective in practice. We found there were some gaps in policy, procedure and the way in which the manager checked the quality of the service. For example, we saw from care records, that some people had sustained falls. The manager told us they did not have a falls procedure to guide staff in the event of a person falling. We saw from accident records that there was inconsistency in how staff had reacted to people falling, for example, whether medical assistance was sought.

We found the monitoring tools to ensure medicines were administered safely required improvements. For example the service had not completed the assessments of competency to administer medicines safely for all staff members and the frequency of the medication audits needed to ensure that errors could be identified and dealt with in a timely manner.

We saw that there were inconsistencies in the entries made on people's repositioning charts. These were people who required pressure relief to maintain healthy skin. For example, we found gaps of recording to show whether the person had been repositioned or not. We also found gaps in fluid charts, which were being used for people who were at risk of dehydration. These gaps had not been identified through the use of an effective records auditing process, despite one having been conducted monthly.

We saw that some care plans were not updated. For example, one person's care records said they received oxygen. We saw that this person did not have oxygen with them. A staff member explained that this had not been required for some time. This meant that effective care record audits had not identified where care plans were out of date.

The manager conducted other audits to ensure the quality of the service. For example, the manager had completed a recent infection control audit. We saw that the manager had also worked with the local infection and prevention team in order to improve the way in which people were protected from potential infection. We found that the manager had taken action against any identified shortfalls.

The provider had carried out a survey in December 2014. The provider addressed any issues which were raised. We found that, where audits had identified performance issues, these were addressed with the relevant members of staff.

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	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 (1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Care and welfare of people who use services** The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Consent to care and treatment** The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

This section is primarily information for the provider

Action we have told the provider to take

Requirements relating to staffing

The registered person did not operate effective recruitment procedures in order to ensure that persons employed for the purposes of carrying on a regulated activity were of good character.