Gold Care Consultancy Ltd

Wood House

Inspection report

7 Laurel Close
Tooting
London
SW17 0HA
Tel: 020 8672 4332
Website: www.goldcarehomes.com

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Ratings

Overall rating for this service	**Inadequate**
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?	**Inadequate**

Overall summary

The inspection took place on 10 and 11 March 2015, the first day was unannounced and we arrived at 7.00am. On the second day our arrival was expected. This inspection was carried out in response to concerning information received; a fire had occurred in a bedroom within the home and a person who used the service had died. The circumstances surrounding the fire were still under investigation at the time of writing this report so we have not been able to include information about this incident. The service was due to close on 30 March 2015 for reasons unrelated to the fire.

Wood House is a care home for older people, many of whom live with dementia or mental ill-health. If nursing support is required for an individual this is supplied by local NHS community nurses. The home is registered to provide care for up to 34 people, but it was scheduled to close at the end of March 2015 so there were only 16 people resident there on the first day of our inspection. Of these, nine were long stay residents for whom new homes were being sought (one was in hospital and two moved into new homes whilst we were there), four were

Summary of findings

in the home for a short period of respite care and three were using the home as a stepping stone prior to returning to their own homes after a hospital stay – this is known as the 'step down' service.

The home is located on the ground and first floor of a larger building. Situated on the ground floor are the office, kitchen and laundry, as well as a large lounge, small outdoor smoking area and a bathroom which are used by people who used the service. All the bedrooms are on the first floor which is divided into four units. Each bedroom has its own en-suite toilet and hand basin. The units are not completely self-contained, people can move freely between them. Each unit has its own small lounge, kitchenette, communal bathroom and shower room.

A registered manager was in place. 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 that staff were kind and caring, the food was good and plentiful, cleaning was thorough and people's medicines were administered correctly, but the standard of care was undermined by the poor systems in place within the home.

In particular we were concerned that staff were not taking full account of people's individual care plans and associated risks when providing them with care and support. Managers had not picked up on this because some of their monitoring systems did not identify problems. There were breaches of regulations relating to safeguarding, care and welfare and assessing and monitoring the quality of service provision. You can see what action we told the provider to take at the back of the full version of the report.

We also made some recommendations which the provider needs to consider if the home stays open. These related to reviewing the admissions criteria to ensure they match the skill mix of staff and enhancing social and emotional care.

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. There had been a fire on the premises and staff had not given sufficient consideration to the risks that might be encountered by people who went out on their own.

Safer recruitment practices were followed. Staffing levels had not been reduced, despite people moving out of the service.

Medicines administration was well organised and the home was kept clean.

Is the service effective?

Requires improvement

The service was not effective in all areas. Staff did not apply the knowledge gained from training in dementia and mental health care to everyday practice.

Most staff did not know who was subject to Deprivation of Liberty Safeguards and what they had to do to maintain the safeguards.

People who used the service enjoyed the food provided and were supported to access healthcare services.

Is the service caring?

Requires improvement

The service was not caring in all aspects. This was because social and emotional care was not given sufficient attention. However, staff were kind and respectful.

Positive relationships had been established between staff and people who used the service.

Is the service responsive?

Requires improvement

The service was not responsive. Care plans were in place, but staff were not making reference to them when delivering care so some people's needs were overlooked. However, care staff were aware of individuals' likes and dislikes.

Few social or leisure activities were taking place as staff were engaged in taking people to view the new homes identified for them.

Is the service well-led?

Inadequate

The service was not well-led. The systems put in place by the provider were not identifying problems and the data collected was not being used to improve the service.

There was a culture of noting things down, but not always recording the outcome of any follow up.

The provider gave all interested parties, including people who used the service and staff, the opportunity to comment on the service by issuing a questionnaire annually.

Wood House

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 on 10 and 11 March 2015, we arrived unannounced at 7.00am on the first day of the inspection, the provider expected us on the second day. An inspector and a specialist advisor carried out the inspection. The specialist advisor was an experienced mental health practitioner and had particular expertise in safeguarding adults.

A Provider Information Return (PIR) had not been requested from the provider. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with eight people who used the service, nine staff, including the registered manager and the cook, a friend of a person who used the service and one healthcare professional. We received emailed information from a commissioner of the service.

We looked at two staff files, four care files and four social files, as well as a wide range of the provider's policies, procedures and records that related to the management of the service.

Inadequate

Is the service safe?

Our findings

At the end of January 2015 there was a fire in a bedroom at Wood House and a person who used the service died. The circumstances of the fire are under investigation so we cannot refer further to it at the time of writing this report.

People who used the service told us they felt safe and liked living at the service. Typical comments included, "Yes I do feel safe here" and, in reference to their bedroom, "It's lovely". However we found that there were some issues within the service which impacted on the safety of people who used the service.

Staff told us they were aware of their responsibilities for safeguarding people who used the service, they could describe signs of abuse they would look out for. There was some evidence that safeguarding referrals had been made to the local authority and were investigated. However, we found insufficient consideration of safeguarding in care planning. In particular, in relation to people who went out on their own, some of whom had a history of vulnerability within the community prior to moving into the service.

When safeguarding issues had been considered during care planning we could not be sure that they had been followed through. For example, at least two people's care plans stated that staff should check if these people wanted to receive visitors before the visitor was admitted to the unit. The daily working records did not contain evidence that this had been done or the names or relationship of the visitors. There was up to date information about raising safeguarding concerns in the office, but some of the flowcharts and other information held in the units was out of date.

We found that individuals had risk assessments in place, but they did not cover all risks associated with the person, for example, in one case a person who went out on their own chose to wear their pyjama bottoms at all times. This caused concern amongst the public and may have made the person vulnerable to abuse. There was no risk assessment in place for this frequent activity, nor had any steps been taken to minimise risks, for example, alternative light cotton garments could have been suggested to the person in place of the pyjamas.

These issues amounted to a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse, which corresponds with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they were aware of the provider's whistleblowing procedure, but they had never had cause to use it.

There was a log of accidents and incidents in the home and the predominant theme was slips, trips and falls. We saw that some general preventative measures had been taken, such as the removal of trip hazards, and staff had undertaken falls prevention training.

We looked at the cleaning schedule for the home which contained a basic list of tasks, but no daily/weekly/monthly checklist to complete. This made it hard to know if everything was being cleaned at the correct frequency. However, we observed domestic staff carrying out cleaning to a high standard and the home looked clean, despite wear and tear detracting from its overall appearance. The kitchen had received the top score for food hygiene at its last inspection.

We did not look at staff recruitment in detail, due to the imminent closure of the home, but we reviewed two staff files and saw that safer recruitment procedures had been followed, this included undertaking criminal record checks and obtaining references prior to appointment.

At the time of inspection staffing levels were good, as despite people moving to alternative placements and the reduction in the number of people using the service the original staffing levels had been maintained.

Call bells were available in all bedrooms within the service, most people who used the service told us they did not use them as they did not have mobility problems. We observed that call bells were not permanently located within the toilets or bathrooms, as the bells in people's bedrooms could be taken with them and plugged in to the system. This was not the best arrangement for people with an impaired memory who were able to go to the bathroom independently and there were many who fell into this category within the service. We heard one person banging loudly on the toilet door for help as they had not taken their call bell with them.

We observed staff members administering medicines using a monitored dosage system provided by a pharmacy.

Inadequate

Is the service safe?

Medicines administration records were completed to a high standard, there was good attention to detail and this extended to the application of creams and lotions. When we spoke with a local healthcare professional they described the medicines practice as "exceptional", they said senior staff required prescribers to be very specific and referred back to them if there were any discrepancies. We saw that a pharmacist had visited to carry out a medicines audit and they had made one recommendation which had been taken on board. Some people self-administered their medicines and risk assessments and appropriate arrangements were in place for this.

The home had recently revised its evacuation plans, however we found that staff on the units were not very familiar with people's recently updated personal emergency evacuation plans (PEEPs) as they were stored in the office. However, the staff we asked were aware of those who would need most assistance in the event of an emergency.

Requires improvement

Is the service effective?

Our findings

A person who used the service said, "I'm well looked after." We found that whilst people had their daily needs attended to, there were areas of care where effectiveness could be improved, especially in relation to dementia and mental health care.

Staff were experienced and had undertaken a variety of training, however this knowledge and experience did not always translate into practice to ensure that people's assessed needs were met. For example we saw evidence that longstanding senior staff had completed a Qualifications and Credit Framework (QCF) level 2 course in dementia care in 2012 and a similar course in mental health. However we did not find any strategies or environmental adaptations in place to support people living with dementia or mental health needs.

We found the registered manager to be knowledgeable about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). There was evidence that people's capacity to make their own decisions about moving on had been assessed, with applications for DoLS made to and considered by the supervisory body (the local authority) when necessary. However we found that care staff were less well informed. We observed that staff were very mindful of people's right to make their own decisions whenever possible and we saw them informally checking their consent before they assisted them with various tasks. Care staff could not tell us which people were subject to DoLS or the restrictions that applied to them, although they all told us that they had received training in the MCA and DoLS. They did know who needed to be escorted when they went out, but they had no idea if this was a condition of DoLS or for another reason. We found that DoLS information was mainly held in people's 'social' files in the office so it was not always readily available to care staff. As they were not clear about the application of DoLS there was a risk that they would not uphold the safeguards for those to whom they applied and that they would restrict others without proper justification.

These issues amounted to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services, which corresponds with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A healthcare professional told us that the service had admitted people in the past with very complex behavioural needs which staff found challenging, they felt that people with these needs were not best placed in this home. This was not an issue at the time of inspection as some people had moved out.

The provider's training matrix format was unhelpful, as it was hard to know which staff members were in need of which training. This was because it was set up to indicate that refresher training was due every year, even if it was needed more frequently or not required at all. However, we saw that staff had received mandatory training in line with the provider's policy, a few were slightly overdue refreshers (by up to six weeks) which had not been arranged due to the imminent closure of the home.

When we looked at two staff files we saw that neither staff member had received supervision from their line manager in line with the provider's own policy, or if they had this had not been recorded, as staff members confirmed to us that they had received regular supervision. Staff were unable to describe when they had been updated about best practice in any area, but said there were plenty of opportunities to pass information on at handovers. Handovers were not recorded so only staff on duty would receive updates.

We saw minutes from quarterly staff meetings and there had been extra staff meetings about the home's closure. We found lots of evidence that 'here and now' information was passed on well. For example, we observed the handover from night to day staff and found that staff were informed about individuals' general well-being and any plans for the day.

People were complimentary about the food provided. One person said, "The food is very good; the meat is very well cooked" and another said, "You get plenty of grub." The people who remained at the home ate and drank independently. People's weight was checked monthly with the aim of ensuring that any significant gains or losses were investigated. Basic errors in recording people's height and Body Mass Index (BMI) made this more difficult. The cook met with each person who arrived at the service to find out their likes and dislikes and these were taken into account during menu planning. We saw that at least one person was on a high fibre diet to help with a medical condition. There was a menu plan offering two choices for each meal as well as light options.

Requires improvement

Is the service effective?

People were supported to access healthcare. A healthcare professional we spoke with confirmed there were good links with the GP practice which covered most people staying in the home. We listened to senior staff negotiating with another GP practice about a person who was using the service for a short stay to ensure they could access healthcare services during that stay. If people received community nursing services, visits were recorded by the nurses in files kept in the person's bedroom. We saw evidence of regular visits by Community Psychiatric Nurses in some people's care files.

If the home does not close, we recommend that the provider seeks advice and guidance from a reputable source to review its admissions criteria to ensure it matches staff skills, knowledge and experience.

Requires improvement

Is the service caring?

Our findings

One person who used the service told us that staff were "helpful and friendly", another described them as "alright" and one person said, "[Staff] are all my friends here, they're kind." A regular visitor said staff were "caring". Staff members stressed to us that it was a difficult time for people who used the service, due to the closure of the service. One staff member said, "We care about [the people who use the service] and what happens to them."

We observed staff treating people with respect and maintaining their privacy and dignity whilst assisting them with personal care. Staff were understanding of and patient with the habits and preoccupations some people had acquired due to their mental ill-health and spoke about everyone who used the service very fondly. Staff told us that due to the closure of the service some people's friendship groups had been broken up and they and the people affected were sad about this. We did not observe much interaction between people who used the service during the inspection and this may have been a contributory factor.

On the second day of our inspection some staff had personal interviews with the provider to find out about the individual offer being made to them as a result of the impending closure of the service. Despite this we saw that they maintained a professional approach, ensuring cover was in place when they went for their interviews and not discussing their hopes and fears in front of people who used the service.

We saw from minutes that people who used the service had the opportunity to participate in regular residents' meetings and they were present at meetings to plan their own moves into alternative accommodation. Advocacy support had been arranged for those without relatives who needed help to put forward their views about their future. None of the people we spoke with could tell us where they were moving to, despite their involvement in planning. They may have benefitted from visual prompts, such as photos of their new home.

Staff spoke kindly to people and shared jokes. They understood them when their speech was unclear, this required careful listening. There was emphasis on people's physical well-being, but not so much on their social and emotional care in daily working practices, for example one person's care plan said their mood should be monitored, but it was not.

People were supported to maintain their independence and we observed that staff shadowed one person when they walked around so they could quickly assist if they started to wobble. Another person made a cup of tea for themselves.

Requires improvement

Is the service responsive?

Our findings

One person told us, "There is nothing to do, it's boring". People who used the service knew they could raise a complaint, but were not sure of the formal channels. One person said, "I'd just talk to someone." We found evidence to substantiate these comments.

Care plans had been written based on pre-admission assessments, they were written in clear non-judgemental language, but there was little evidence that they directly impacted on staff practice. For example, one care plan indicated that one person's bowel movements needed monitoring, but this had not happened, yet their regular consumption of a biscuit with a cup of tea was noted by almost every shift. This indicated that staff were not receiving sufficient guidance about referring to the care plan or recording priorities. Some staff members were unaware of people's life history, some of which may have explained aspects of their behaviour or attitudes. An outline of people's life histories appeared in both the pre-assessment information and their care plans, this was further evidence that care plans were not regularly referred to.

In another person's care file it stated, "Staff in the home will closely monitor [the person's] medical and physical health conditions and refer any noted significant changes to [their] GP and the Community Mental Health Team accordingly." Yet there was no guidance for staff about what constituted a significant change or what symptoms might indicate a relapse for that person who had a severe and enduring mental health condition. Again, their tea and biscuit consumption was regularly recorded, but there was no reference to their mental health in the daily working records. Some of the care plans also contained out of date information on people's medicines because these changed frequently, but medicines administration records were up to date.

Care plans were reviewed monthly by staff without involvement from people who used the service. The review records that we saw simply stated, "the [care plan] objectives remain the same". Reviews were based on the information in the care files, reference was not made to people's other files, therefore they were based on incomplete information. We found changes were not always reflected in care plans, for example, in relation to Deprivation of Liberty Safeguards. A local authority confirmed to us that staff at the home had been "extremely cooperative" when helping them to move people into their new homes, but we were concerned that, due to the incomplete reviews, there was a risk of inaccurate information being passed on to people's new homes. We brought this to the attention of the provider and the Registered Manager said they personally checked the information before it was handed over which reduced the risk, but only when he was available.

These issues provided evidence of a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services which corresponds with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Pre-admission assessments were carried out by senior staff from the home. There was also evidence of assessment by various healthcare professionals, for example, community psychiatric nurses (CPNs), which had been carried out in response to a request from the home or when the CPN themselves felt a person's needs had changed. We found that pre-admission assessments considered how people's needs in relation to equality and diversity could be met, but if people were reluctant to discuss these matters at this early stage there was no evidence that the subject was brought up again once trusting relationships had been established.

We found when we spoke to staff that they were aware of each person's basic personal care needs within the home, their likes, dislikes and personal preferences. This was confirmed when we observed a handover between shifts. We saw that one person received personal care from a staff member of the same gender as themselves as this was their preference.

Staff knew what was 'normal' for each individual and we heard them arranging for someone to see a GP when something which was not normal for them occurred. We observed people being routinely offered choices, for example, one member of staff asked a person who used the service, "Would you like to eat now or are you planning to have a sleep?"

No social or leisure activities, apart from watching television, took place during our inspection. This was due, in part, to the activities coordinator being out visiting new homes with people or helping them to move. Some people

Requires improvement

Is the service responsive?

who used the service took themselves out to the local shops. One person's care plan stated, "Staff will provide the person with a programme of organised social activities within and outside the home on a daily basis", but when we looked at the daily records for 2015, apart from one visit by a family member, the only activities this person had undertaken were reading the paper and watching television. Elsewhere in the person's care plan it said they did not watch television.

We saw information about the first stage of making a complaint was displayed prominently around the service in an easy read format. At least one person had an out of date poster behind their bedroom door telling them how to make a complaint to the previous provider.

If the home does not close, we recommend that the provider seeks advice from a reputable source in order to enhance, monitor and evaluate the social and emotional well-being of people who use the service.

Inadequate

Is the service well-led?

Our findings

There was a positive, friendly atmosphere within the service despite its imminent closure. The registered manager and staff wanted to do a good job and to support people appropriately. The registered manager was described by staff as "very supportive", especially when people who used the service were abusive towards them.

However, the inadequate systems within the home impacted on the standard of care. Staff were diligently recording things, but there was little evidence of analysis or action taking place as a result of their recording. Records were failing to identify problems at an early stage and were not being used to monitor, evaluate and subsequently improve individuals' care. The provider had not identified the shortfalls found during the inspection and therefore the quality assurance systems were not effective. For example, a regular care plan audit was carried out, but it only reviewed whether or not the relevant documents were in the care file. It did not address the quality of the reviews or the appropriateness of the recording which was taking place, nor did it consider the records held by the service which were not in the care file.

The lack of analysis may have been due, in part, to the structure of the provider's audit forms, all of which resulted in almost perfect scores. We found that in order to get an overall score for some audits the person completing it had to confirm that items which were not present in this care home were in fact in use. The non-availability was usually, but not always, indicated by "n/a" in an adjacent column, but it made it very hard for anyone to analyse the data, such as staff in the provider's head office, unless they were very familiar with the service and its occupants. Some questions were difficult for staff to assess, for example, an infection control audit form required them to confirm the provider's policy was "compliant with the 2010 regulations" and in other cases positive scores may have been given without checking, for example, one completed infection control audit form stated that all staff received regular supervision when we could not find evidence of this in the two staff files we looked at.

Splitting people's care records between several files hindered good practice as key information was not systematically or accurately cross-referenced. The care staff we spoke with directed us to the care files they worked with on the units, but it emerged that the GP and community nurses also had records on site and there was a separate social file for each person in the office. Senior staff were able to answer questions we asked them about individuals' healthcare arrangements, however, we found that this information was often not recorded. This was particularly concerning when everyone's care was due to transfer to a new provider.

The arrangements for the storage of information also had the potential to impact on people's legal rights. Some information about people's legal circumstances was not written down. For example, there had been an issue with a person's Lasting Power of Attorney (LPA) which had been resolved and which the registered manager could explain, but this information was not recorded in the person's file which still contained the details of their previous LPA. In addition we found a discharge summary, which had not been issued, but stated that DoLS were in place for a person when they had not in fact been granted.

These issues constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision which corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Questionnaires were distributed annually to people who used the service, their relatives, visiting professionals and staff to gather their views on the service. We looked at the most recent questionnaire completed by people who used the service in April 2014. The responses were overwhelmingly positive in every category.

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 and nursing or personal care in the further education sector	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment; systems and processes were not established or operated effectively to prevent abuse of service users. Regulation 13(1)(2) This corresponds to Regulation 11 HSCA (RA Regulations 2010.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users was not always appropriate, nor did it always meet their needs. Relevant people were not always enabled or supported to make, or participate in making, decisions relating to the service user's care to the maximum extent possible. Regulation 9 (1) (a)(b) (2)(d) This corresponds to Regulation 9 HSCA (RA) Regulations 2010.