Care Quality Commission

Hampshire County Council

Willow Court Nursing 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection took place on 19 and 23 January 2015 and was unannounced.

Willow Court is a purpose built nursing home, in the grounds of Andover War Memorial Hospital. The home provides care for up to 66 people, some of who are living with dementia. There were 60 people using the service at the time of this inspection.

The service had a registered manager. 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.

The majority of people were complimentary about the service they received. However, our own observations and the records we looked at did not always match the positive descriptions people and relatives had given us.

Although people told us they felt safe and they received their medicines on time, we found good practice was not always followed for the recording of medicines or the assessment and administration of as required medicines, particularly around pain relief.

Summary of findings

There were enough staff to meet people's needs and a system was in place to monitor and vary staffing levels if people's needs changed. The service carried out appropriate recruitment checks to help ensure that staff were suitable to work with people at risk.

Staff were aware of their responsibilities in regards to safeguarding and reporting any issues of concern. They were confident to use the relevant policies and procedures and had received training to support them in keeping people safe.

Staff were knowledgeable about the wishes and needs of the people they supported. We found care planning required improvement as there were some gaps within the care records which did not always include specific guidance for particular needs.

People were treated with dignity and respect. Privacy was maintained and staff offered choices and involved people in their care.

People were supported to have sufficient to eat and drink. Snacks and drinks were available during the day. Specialist needs were responded to. Family and friends were able to visit and told us they were kept informed about their relative.

Staff had mixed views about the effectiveness of communication with the management. Relatives and people were not always fully involved in the running of the service.

Staff involved relevant health professionals and responded quickly to people's changing health needs. Staff were supported by the registered manager and received relevant training and supervision to support them in their roles.

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

Some aspects of the service were not safe.

There was a lack of specific guidance in relation to when staff might need to administer pain relief and other as required medicines.

Staff were aware of their responsibilities to keep people safe and were confident to report any concerns they may have.

There were suitable recruitment procedures in place and sufficient staff to meet people's needs.

Is the service effective?

Good

The service was effective.

The staff were aware of the Mental Capacity Act 2005 and how to support people to consent and make choices. The registered manager and lead staff were knowledgeable about the Deprivation of Liberty Safeguards and appropriate applications had been made where a person was deprived of their liberty.

Staff received relevant training to support them to deliver care effectively.

People had access to relevant health care professionals and received appropriate assessments and interventions to maintain their health. Staff kept relevant health care professionals informed and updated as appropriate.

People were supported effectively to make sure they had enough to eat and drink.

Is the service caring?

Good

The service was caring.

We saw positive and caring interactions between staff and people using the service.

People were treated with dignity and respect. Privacy was maintained and staff explained what they were doing when providing care to people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always contain clear guidance for staff to follow around specific needs.

It was not clear how the activities offered always met the needs and wishes of the people using the service.

Summary of findings

Staff were knowledgeable about the people they were caring for and responded to requests for assistance.

People were aware of how to complain and any complaints were dealt with in accordance with the home's policy and procedure.

Is the service well-led?

Requires Improvement 

The service was not always well-led.

The registered manager promoted good relationships other professionals who supported the service.

There were not clear systems in place to involve people and their relatives in the running of the service. There were mixed views from staff about the effectiveness of communication with the management of the service.

Staff were well supported by the registered manager to undertake their roles and responsibilities. A regular programme of monitoring and quality assurance supported the staff and registered manager to assess the quality of the service and implement improvements.

Willow Court Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 19 and 23 January 2015 and was unannounced.

The inspection was led by an inspector who was accompanied by a specialist advisor and an expert by experience. A specialist advisor is someone who has experience and knowledge of working with people who are living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had personal experience of caring for someone who lived with dementia.

Before we visited the home we checked the information that we held about the service and the service provider, including notifications we received from the service. A notification is information about important events which the provider is required to tell us about by law.

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

We reviewed a range of care records for six people, including nursing and personal care assessments, daily health monitoring records and records of visits by healthcare professionals. We looked at the medicine administration records for 42 people. We also reviewed records about how the service was managed, including risk assessments and quality audits.

We spoke with 12 people who live in the home and two relatives of people who used the service. We also spoke with the registered manager, two deputy managers and ten other members of the nursing and care staff. During and after the inspection we received feedback from two external health and social care professionals who were regularly involved with the service.

We last inspected the service on 12 December 2013 where no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

All of the people we spoke with said they felt safe. They and their visitors also commented that staff were kind and treated them well.

Whilst people told us they felt safe, we found some areas which required improvement. We looked at all the Medicines Administration Records (MARs) relating to all of the people living at the home and found some areas required improvement. The MARs were fully completed and up to date. However we identified some recording and administration issues. For example, one person had been prescribed three different types of pain control but there was a lack of clarity about when each should be administered. This could lead to the risk that the person may have received too many or too few analgesics to adequately control any pain they experienced.

From our review of 42 MARs we found that more than half of the people had been prescribed 'as required' (PRN) pain control medication. The provider did not use PRN care plans which provided guidance for staff on the signs or symptoms which might indicate the person needed their 'as required' medicines. . We found the provider used a pain assessment chart for some people but not on a routine or regular basis. This meant staff decided when the pain assessment tool should be used, which is contrary to best practice guidance.

The MAR's showed that 25 people had been prescribed medicines for mental health conditions and/or cognitive impairment. This meant some people may not have been able, because of difficulty with verbal expression, to explain any pain they experienced.

Five people had been prescribed medication often given for agitation. People's records showed this should be given for "agitated behaviour". Agitation is indicator behaviour. This means it is the physical sign of something else such as pain, infection, anxiety, hunger, boredom or confusion. Because of this it is important that the reason behind the behaviour is investigated and this included in the PRN care plan. For example, if a person's care plan showed what behaviour they usually exhibit when they are in pain, the staff would know it is appropriate to administer an analgesic rather than another medicine to de-escalate their behaviour.

We recommend the provider review their practice with regards to as required medicines and pain assessments in line with best practice.

People confirmed they received their medicines on time. Some of their comments were: **"**I get my medication the same time every day and if you ask the nurse they explain what they are all for"; and "I get my medication every day and the staff tell me why I am taking it, they are very good".

The provider had an effective system of ordering and stock control and the medicines rooms were tidy and well organised. When medicines required cold storage a refrigerator was available and the temperature checked and recorded daily to ensure medicines were stored according to the manufacturer's instructions.

Medicines, including controlled drugs, were recorded, stored and disposed of safely although we saw the disposal box was not of the lockable type. The clinical lead member of staff said they would correct this immediately by placing a new order. Non-lockable boxes carry a small but evident risk of misappropriation of the tablets and capsules held in the boxes prior to disposal.

We observed part of the morning and part of the lunchtime medicines rounds and found that staff administered medicines in a safe manner. The nurses explained to people what the medicine was for and took time to sit with people until they had taken the medicine. Two nurses told us they had annual training and competency assessments, which were carried out by the deputy manager to ensure their proficiency.

We spoke with two care staff about their knowledge of safeguarding procedures. They had a good understanding of what it meant for the people in their care. They described the situations under which safeguarding would be required, for example one care worker said "We hear a lot about this at meetings and in training, I think we would all say the same thing. I know it is my responsibility to keep people safe and report things that are not right". They continued "If I reported something to the deputy and he did not listen I would report to the manager and so upwards until someone listened and I would do this".

The other care worker told us "Safeguarding is keeping people safe and reporting things that are not, as quickly as possible". The staff were familiar with the provider's safeguarding policy and how to locate it. They told us they had received training in safeguarding during the past year.

Requires Improvement

Is the service safe?

Care records showed risks associated with the provision of care and support had been assessed, such as in relation to mobility and falls, nutrition and weight. Staff were aware of the risk assessments in place for people. Staff supported people in ways that protected them while respecting and promoting their freedom and independence. For example, a care worker assisted a person to go to their room by following behind while the person used their walking frame. This was done at the person's own pace. The person told us "The staff encourage me to do things even if it takes a long time". Another care worker explained how they enabled a person to take a bath as independently as possible.

The staff rota was planned and organised in advance to ensure there were sufficient numbers of suitable staff to keep people safe and meet their needs. Staffing levels at the time of the inspection matched those recorded on the rota and were sufficient to meet people's needs. The registered manager assessed and monitored people's needs to identify if additional staffing was required. Following a change in the assessed needs of two people, an additional member of care staff had been deployed on the ground floor. This showed that staffing levels were reviewed and increased if necessary. There was a low turnover of staff at the home so people received consistent care and support.

There were appropriate recruitment processes in place. There was a system for ensuring relevant checks had been completed for all staff. This included Disclosure and Barring Service (DBS) checks; confirmation that the staff were not on the list of people barred from working in care services. Records were also on file showing that checks were also undertaken to ensure that nursing staff were correctly registered with the Nursing and Midwifery Council (NMC). All nurses and midwives who practise in the UK must be on the NMC register.

Good

Is the service effective?

Our findings

People said the staff understood their needs, so they received effective care. They gave examples of how staff supported them to maintain their independence. They confirmed they received on-going healthcare support, for example chiropody appointments and the offer of flu vaccinations. One person remarked: "They like to keep us healthy". Another commented: "I am comfortable here and the care is good". A visitor told us: "I would say the staff have the correct skills and training. If my husband is unwell the GP comes very quickly".

The staff we spoke with demonstrated an understanding of how to promote people's independence and how to ensure that people were offered choice in their day to day care. A care worker told us: "When getting decisions from the residents for example I get two blouses out of the cupboard and ask which one they would like to wear. They point to the one they want to wear. I always ask consent and the resident usually nods to let me know".

Senior staff were given lead roles in ensuring the principles of the Mental Capacity act (2005) were adhered to and staff received training in these principles. The Mental Capacity Act 2005 (MCA) is a law that protects and supports people who do not have the ability to make decisions for themselves.

Care plans stated when a person had the capacity to make decision about everyday life such as what to wear and what to eat. We saw care records showed where family members had been consulted about a person's care. Some people had Do Not Attempt Cardio-Pulmonary Resuscitation forms in place. Where a person was considered unable to sign their consent for this, they also had a mental capacity form to show this. However, we saw some signatures on these forms from family members but there was no indication the person had the legal right to do so for example if they were acting as the person's power of attorney for health and welfare.

Two visitors told us they had power of attorney and the home involved them in making decisions in their relatives' best interests. Two health and social care professionals confirmed that people's consent was sought and mental capacity assessments were carried out when required, for example in relation to the use of bed rails.

Both deputy managers had received training and understood when a Deprivation of Liberty Safeguards application should be made and how to submit one. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Following a Supreme Court judgement which clarified what deprivation of liberty is, the management had reviewed people in light of this and submitted more applications to the local authority. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards. We saw records of applications submitted and those that had been authorised.

Records showed people had access to healthcare professionals such as general practitioners, specialist older people's mental health teams, occupational therapists and a range of community nursing staff. We received feedback from two health and social care professionals who were involved with the service. They told us the staff kept them informed and referred people to health services appropriately. They also told us the nursing staff were always helpful and had the relevant knowledge and current information about people who were referred.

Staff knowledge and skills were supported through supervision meetings and individual performance plans, which provided an on-going appraisal of their work and development needs. There was a comprehensive induction, training and development programme and a system for monitoring staff attendance on courses. The induction for new care staff lasted four weeks and was based on the Skills for Care common induction standards, which are the standards people working in adult social care should meet before they can safely work unsupervised. In addition to essential training to carry out their roles safely, care staff attended dementia awareness training and were encouraged to undertake diplomas in health and social care. A Practice Development Nurse (PDN) had responsibility for implementing a competency framework for the clinical development of nurses working in the home.

Staff confirmed they had been trained in moving and handling. We observed six moving and handling processes during our visit, which involved the use of hoists and stand aids. These were carried out efficiently and competently.

Good

Is the service effective?

During these procedures the staff spoke with the people they were assisting, providing them with reassurance and describing the process. People seemed relaxed and appeared to have confidence in the staff.

People were supported to eat and drink enough to meet their needs. One person told us: “The food is always very good and I have a choice. I prefer to eat in my room and they let me. If I am hungry I can have toast”. Another person said: “I have plenty to eat and drink. My teeth are not great so they mash my food up for me”.

Most people were supported to eat while in bed or special chairs. For people who ate in the dining rooms, there were several dining rooms in the home. The staff knew what each person liked to eat, their preferred portion sizes and which drinks they wanted. The food came from the hospital in heated trolleys. Care staff observed good hygiene practice before and during the service of meals. We observed the temperature of food being checked and some being put to one side when it was too hot. Staff told people what they were doing and asked permission to put on a person’s clothes protector. People had suitable equipment to support them to eat independently and people appeared to be enjoying their food whilst staff assisted them and chatted with them.

There was a record of people’s dietary requirements available in each dining area. A care worker said: “We encourage people to eat by offering them a selection of food, especially food we know they like. If the resident has not eaten a meal we tell the nurse and it is recorded. As soon as a resident is on antibiotics we fill in a fluid and food chart because we know they can be at risk of not eating”. Another care worker told us: “I get the resident to eat by showing them what is on the plate and telling them what it is”.

Records contained clear guidance for staff about how they should meet people’s eating and drinking needs. When people had swallowing difficulties they were referred to the local Speech and Language Therapist (SALT). The SALT guidance was included in people’s care plans so that staff had professional guidelines to follow. People were weighed monthly and Malnutrition Universal Screening Tool (MUST) records were up to date. This helped staff to be aware if people were at increasing risk of malnutrition.

Three people at the home had percutaneous gastrostomies (PEGs) which meant they had a tube through which they were provided with food, fluid and medicines. We looked at the PEG care plans and found they were detailed, comprehensive and specific. This meant any new member of staff would be able to identify exactly what the person required to meet their hydration, nutrition and medication needs. There were also clear records relating to the processes to be followed to provide safe and effective care of people’s PEGs. We looked at the equipment being used to provide food, fluid and medicines which were clean and in good order.

Good

Is the service caring?

Our findings

People told us staff were caring. They said staff always knocked on their doors, asked if it was ok to do their personal care and drew the curtains. A visitor told us: "As far as I can see I think the staff are kind to everyone. I am sure they respect (their relatives) dignity. I am able to visit when I want really and I come at all different times.

Another visitor said: "The staff are very kind and compassionate. They do discuss things with me. I am advised about everything that happens. The staff draw the curtains and shut the door before giving treatment, no one comes in without knocking. I am welcome anytime, visiting is supposed to be 9.30 am to 9.30 pm. I could stay all night if I needed to".

Staff provided people with support in a friendly and caring manner. When people asked for assistance staff provided this quickly and cheerfully. They positioned themselves on the same level with the person they were talking with and made eye contact. Staff were patient toward people who had difficulty with verbal communication. They knew people's individual preferences and dislikes and were able to quickly identify people's needs and respond to these promptly. During the morning coffee round the staff knew which biscuits each person liked best and how they liked their drinks in terms of type, strength and amount.

Staff provided care in ways that respected and promoted people's privacy and dignity. They knocked on doors before entering people's rooms and closed the door when any kind of care was being provided. When people required some personal care the staff behaved in a discrete manner before supporting them to leave communal areas. A care worker described to us how they supported one person to dress in a manner that protected their dignity. They said, "It is just being aware of how I would like to be treated and getting to know the resident".

One care worker said: "When I am doing care I look after the resident how I would like my family to be looked after. If the resident is not able to verbalise, I would give them the flannel and show them how to wash their face". Another care worker told us "I let X stay in the bath on her own for a while, she likes a soak. I know she likes to have her hair washed and a bit of privacy. I am never far away. I feel it is important she has some freedom". Another care worker told us "I always ask consent, close the curtains and shut the door. I try not to leave anyone exposed".

A care worker told us "I make sure I know the names of their children and husbands, especially if the husband has passed away. I like to know how they like their tea and coffee, just little things that make a difference. It is nice to be able to chat to the residents, as I do their care, about things that are important to them".

Requires Improvement

Is the service responsive?

Our findings

People told us the service was responsive to their overall health needs. For example, one person said: "If I am feeling unwell they get a nurse and then a doctor if I need one. I have never had to complain, I would tell a nurse if I was unhappy. The staff listen to me".

Before people moved into the home their needs were assessed. This ensured the service was able to meet the needs of people they were planning to admit. Care plans were written in a person centred way. There were some ways that these could be enhanced by a more detailed completion of people's life history and/or 'This is me' documentation, which did not always contain up to date or complete information.

On the whole people's records were reviewed each month and risk assessments carried out and new care plans created when necessary. We found there were some gaps in the records, for example, when people had an infection such as urinary tract infection or chest infection their records did not contain short term care plans, which would have provided instructions for staff about how to support people to assist their recovery and increase their comfort. For example, both urinary tract and chest infections can cause discomfort that can be eased through the provision of simple support measures such as additional fluids and regular analgesia.

The provider did not use specific and detailed continence support care plans. This meant staff did not receive guidance about each person's individual continence needs. People's elimination care plans were basic and did not include information about the frequency of absorbent pad changes or the specific ways staff should support people to remain independent for as long as possible, for example by supporting them to use the toilet at regular intervals that suited the person's natural flow.

We spoke with two care staff specifically about their knowledge of people's care needs. They told us they used care records as a source of information when necessary. However one told us "we get handover and look at the daily records as we do not always have time to look in the care plans, but the nurses who use them several times a day know them really well".

A member of staff told us "I talk to the resident all the time and tell them what I am doing. I look for non- verbal clues if they can't tell me how they feel. We get to know the residents so well we realise if something is wrong. The other day someone had gone off their food, which was unusual. They were also fidgeting in the chair, so we did a urine test and called the doctor as they had a water infection".

We received mixed feedback in relation to the activities and interaction with staff. One person told us: "There is nothing for me to do all day and I used to be so active. I don't want to go in the lounge there is no one to talk to". A visitor said: "There are no activities as far as I can see. My mum is always sat in this position in front of the TV". They added that a review of their relatives care was scheduled to take place. Another visitor commented: "My husband went to some of the activities but he didn't like it. He hasn't really got any interests or hobbies".

Staff went about their duties calmly and responded to people's support needs in a timely manner. People told us they did not have to wait long for their call bell to be answered. In the afternoon staff spent time sitting and chatting with people.

A care worker told us: "I speak to the family and get to know the resident by asking questions. I have no criticism of the current activities, my thoughts are with the people in bed all the time; they don't get any sort of activities. If there have been any complaints about the home we discuss the issues in staff meetings".

Another member of staff said: "I personalise the care by chatting as I wash the resident. I make sure the door is shut and the curtains are drawn. I keep telling them how good they are getting at washing and things. The activities are getting good at the moment. We try to do one to ones for the residents who are in their rooms; we like to do their nails and things like that".

An activity took place involving 16 people holding on to a large piece of material and keeping two balls bouncing in the middle. Those taking part were clearly amused and having fun. On another occasion a sing-a-long session was attended by a dozen or more people. Staff supported those people who wished to attend to move from their rooms to the communal area. We saw records were kept showing both one to one and group activities were offered and took place. A chart was kept to monitor activities offered, declined and participated in.

Requires Improvement

Is the service responsive?

The manager subsequently informed us that activities were a standing item on relative and residents meetings and were in the newsletter sent to relatives. The newsletter contained a slip to return if they have any comments or requests. However, it was not clear from this what follow up there was to ensure activities were personalised to the individuals to help meet their needs and preferences.

We recommend the registered manager reviews the activities offered to help ensure they meet the needs and wishes of the people using the service.

Most people we spoke with told us they had never needed to make a complaint. One person said he had raised a concern with the deputy manager and it had been dealt with and resolved. A system was in place to monitor and respond to any concerns or complaints about the service. The registered manager kept records of complaints, the actions taken in response and the outcomes. This demonstrated that the manager and provider listened to people's experiences and concerns and took action when necessary.

A member of staff told us "We have staff meetings and changes are made. If I have got a concern I tell the management".

Requires Improvement

Is the service well-led?

Our findings

People told us they were well looked after and they and visitors we spoke with said they would recommend the home to others. Some relatives said they were not asked for their views about the service and any changes were not discussed with them. One person and a visitor said there was a newsletter that helped to keep them informed.

The registered manager was working on improvements to seek people's views about the service. A quality assurance survey questionnaire was given to visitors during the time of the inspection. Twelve relatives completed the survey during this time and the majority of their responses were positive, with one or two other comments of a minor nature. The registered manager said she would be collating all the responses to see where there might be areas for improvement of the service. Two health and social care professionals who were involved with the service told us the service offered a high level of good quality care and worked well in partnership with them. There were no clear systems in place to actively involve people in the service. The manager told us there were residents' meetings but these were not well attended. Updates from these meetings were included in the newsletter.

We received mixed feedback from staff about the effectiveness of communication with the management team. Two staff we spoke with said they did not feel listened to by the management and that communication could be improved. Another two staff told us they felt supported and could raise any issue they needed to during staff meetings or at any time in an informal manner. These staff told us the manager was approachable and was always available to them. One told us: "Although she (the manager) is busy with office stuff, she always knows what is going on and if you have a problem she is really kind". Another care worker told us "We get supervision every month and we talk about the issues we worry about and the ways we could do things differently, I look forward to it".

Staff we spoke with understood their roles and responsibilities and there were clear lines of accountability. We asked two staff about the provider's visions and values of the home. While the staff were not able to explain their understanding of the provider's visions and values one told us: "I think the manager values residents first then staff which is how it should be". The other staff member said: "The manager wants this home to be the best and so do we, as then the residents would get the best and that would make us all happy".

The managers completed 'walk the floor' reports, including spot checks such as monitoring that pagers were working and being carried by staff. Regular audits of the quality and safety of the service took place and were recorded. For example, there were audits of care plans, medicines and infection prevention and control. In addition to these, a service manager for the organisation carried out regular checks that were also recorded. There was an on-going improvement log completed by the manager, which was a record of actions taken in relation to audits, incidents, and feedback from people using the service or others acting on their behalf. A copy of the report was sent to the service manager and provider.

Procedures were in place for reporting accidents and incidents, including a system for monitoring falls. For example, in the event of a pattern of falls being identified, the local governance team would contact the home to check what action was being taken.

The provider had commissioned a review of the dementia training provided to staff and a date was set for this to take place. A care worker told us a number of staff and people's relatives had previously taken part in dementia workshops, which provided learning opportunities for everyone involved.