Orchard Care Homes.com (3) Limited

Alwoodleigh

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

The inspection took place on 2 February 2015 and was unannounced. We also visited the home on 11 February and this visit was announced.

Alwoodleigh is registered to provide nursing and personal care for up to 40 people. The home mainly provides support for older people and for some people who are living with dementia. Accommodation is arranged over two floors and there is a passenger lift to assist people to get to the upper floor. The nursing unit is based on the upper floor and the residential unit on the ground floor. The service has a manager in place however, they are not yet registered with the Care Quality Commission. The manager had applied to the Care Quality Commission for registration and was awaiting the outcome of their application. 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 told us they did not feel safe at the time of our inspection as a result of a person who displayed behaviour which challenged others. This person had been transferred to more suitable accommodation the day before our second inspection day. Staff and people

Summary of findings

who lived at the home told us that staffing levels were not always sufficient to meet the needs of the people in the home and people had to wait to be assisted at busy times. Staff we spoke with had a good understanding of safeguarding and knew what to do should they suspect any form of abuse occurring. Although we saw evidence that staff had not always followed the correct procedure for reporting abuse.

The home used safe systems when new staff were recruited. All new staff completed thorough training before working in the home and undertook a comprehensive induction.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The manager told us there were no people staying at Alwoodleigh during our inspection who were subject to a DoLS authorisation.

Feedback from people who lived at the home, was that staff were caring. Staff had developed positive, respectful relationships with people and were kind and caring in their approach. People were given choice in their daily routines although this was not detailed in their records. We saw many positive interactions between people in the home and staff. People's nutritional needs were met and they received the health care support they required. People had a choice of meals, snacks and drinks which they told us they enjoyed.

Staff were able to tell us how they respected peoples' privacy and dignity by closing doors, closing curtains and covering people with a towel when undertaking personal care.

We found there was little opportunity for people to be involved in any stimulating or meaningful activity and people told us they would like more activities. The registered provider had a system in place to deal with complaints, however, not all complaints had been recorded.

We found a number of examples where people's care and support records were not always fully completed. We saw the registered provider completed a detailed quality monitoring report every month and undertook a thorough audit of the service provided. The manager had been in place for a short time but had a vision for the service to ensure that the people who lived at Alwoodleigh received the best possible care. You can see what action we told the provider to take at the back of the full version of the 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 always safe.

People told us they did not feel safe at the time of our inspection as a result of a person who displayed behaviour which challenged others. Staff told us they knew how to recognise and report abuse but we saw evidence that abuse had not always been reported.

Staff recruitment policies ensured staff were suitable to work with vulnerable people. However, there were not always enough staff to provide the support people needed.

We found medication was administered as it had been prescribed and the home had safe systems in place for managing people's medications.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received a comprehensive induction prior to beginning employment and received regular training, although we found not all training was up to date. Staff had received regular supervision and had all undertaken an annual appraisal.

No one at the home was subject to the Deprivation of Liberty Safeguards (DoLS). Staff had been trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. We saw reference to people's mental capacity within their care plans and the nursing staff we spoke with had a good understanding of capacity and best interest decision making.

Is the service caring?

Good

The service was caring.

We saw positive interactions between staff and people who used the service. It was clear staff knew people well and understood how to support them.

We saw people's privacy and dignity was maintained whilst staff were assisting people.

We saw staff maximised people's independence and referred people to external professionals such as occupational therapy , podiatry and physiotherapy to achieve this outcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Summary of findings

We found there was limited access to meaningful and stimulating activity.

We observed that staff were not able to respond to peoples call bells promptly.

We saw some people's care plans contained detailed information and these had been regularly reviewed. However, we saw sections in some peoples care plans that had not been fully completed. People's daily logs were not always completed at each intervention.

Is the service well-led?

Requires Improvement

The service was not always well led.

People who lived in the home and their relatives were asked for their opinions of the service.

The registered provider undertook monthly quality audits which were detailed and thorough.

Systems for monitoring staff training and supervisions were not robust.

Alwoodleigh

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.

We visited the home on 2 February 2015. The visit was unannounced. We also visited the home on 11 February. This visit was announced.

The inspection team consisted of two adult social care inspectors, and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed the information we held about the home, which included incident notifications they had sent to us. We contacted the commissioners of the service and the local authority safeguarding team. We also contacted Healthwatch who had recently undertaken an "Enter and View" visit. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The registered provided had not been asked to complete a Provider Information Return (PIR). This 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 used a number of different methods to help us understand the experiences of people who lived in the home. We used the Short Observational Framework for Inspection (SOFI). SOFI to observe care and support in the communal areas. 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 records about people's care and how the home was managed. These included the care plans for five people, and medication records for three people. We also looked at the training records for all staff who were employed at the home, and the induction records of three staff. We spent time looking at the registered providers quality assurance audits and we looked in several bedrooms.

During the first day of our inspection we spoke with ten people who lived at Alwoodleigh and four relatives. We also spoke with two nurses, two care staff, the administrator, the handyman, a laundry assistant, the registered manager and the regional project manager.

Requires Improvement

Is the service safe?

Our findings

We spoke with six people who lived at the home, who told us that they did not feel safe. They told us this was as a result of a person who displayed behaviour which challenged others. When we told the manager of the concerns of people who lived at Alwoodleigh, they immediately arranged for additional staffing to be put in place. This was to support this person whose behaviour challenged others and to ensure the safety of people who lived at the home. This person was waiting to be transferred to more appropriate accommodation on the first day of our inspection and had been moved to more appropriate accommodation by the second day of our inspection.

Staff we spoke with on the day had received up to date safeguarding training and had a good understanding of the procedure to follow if they witnessed abuse or had an allegation of abuse reported to them. Staff we spoke with were able to describe the signs of abuse and what actions to take to ensure people remained safe.

However, one person who lived at the home told us of an incident with the person whose behaviour challenged others. They told us they had reported this to a member of staff. However, we saw no evidence that this had been reported to the manager, which showed us that not all staff were aware of their responsibilities in safeguarding people from the risk of abuse or harm. The registered manager did investigate this incident after we advised what the person had told us, but the complainant could not remember who they had told. The registered manager told us they would ensure that all staff were reminded of their responsibilities at supervision and at team meetings. We reminded the manager of the registered provider's duty to notify the Commission, without delay of any abuse or allegation of abuse in relation to a person who uses the service.

Staff and residents told us that staffing levels were not always sufficient to meet the needs of the people in the home. For example, on the second day of our inspection the manager showed us a dependency matrix. This recorded, of the 23 people on the nursing unit, 18 people needed two staff to assist them. It also detailed, of the 17 people on the residential unit, five people needed two staff to assist them. Two people living at Alwoodleigh also had high dependency care needs. The registered provider's staffing ratio assigned one staff to five people during the day and one staff to ten people at night. However, this did not take into account the dependency of the people who lived there. This meant when two staff were carrying out the care of one person at busy times, staff were unavailable to attend to other people or to respond to any emergencies.

We observed staff were too busy to answer call bells in a timely fashion. Two people told us it took an average of 45 minutes to an hour to get a response during the night. They told us this had stopped them from asking to use the toilet during the night. They told us the staff would take them to the toilet if asked but this was difficult because they were so busy.

Five people made comments about the need for more staff. Low staffing levels also meant staff were only able to focus on care tasks, leaving little opportunity to engage with people in a meaningful social way.

These examples showed us there were not enough staff on duty to meet the assessed support needs of residents. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at five sets of care records and saw each person's support plan included a number of risk assessments which identified risks associated with their care and support. Risk assessments included moving and handling, falls, nutrition and tissue viability.

We spoke with three people who required staff support when transferring and they told us they felt safe and secure. One person said, "I'm never worried or anxious when being lifted. I know what's right or wrong. I've never seen anything that's caused me concern". We saw evidence in each of the records that most people's care needs were reviewed and updated on a regular basis. This meant care and support was planned and delivered in a way that reduced risks to people's safety and welfare.

We looked at three staff files and found all necessary recruitment checks had been made to ensure staff suitability to work in the home. For example, we saw evidence in each file that Disclosure and Barring Services (DBS) checks had been undertaken and two references received for each person. The home's administrator confirmed no staff would be allowed to work with people in the home without such checks in place.

Requires Improvement

Is the service safe?

We were told the home did use agency staff for some night shifts and to cover staff holidays. However, the manager told us they requested staff who had worked at the home before. They also had access to bank staff and had the benefit of the use of staff from the registered provider's other homes in the area. This meant that provider took steps to ensure that staff were knowledgeable about the needs of the people who lived at the home.

People were assisted with their medicines in a patient and reassuring way. Staff spoke with people and explained what their medication was for. We saw staff ask whether people had any pain that required pain relief. People told us they generally received their medication on time although one person told us that on one occasion a temporary nurse had been on night duty and their medication had not been given until 1.40 am.

We saw medicines were stored safely and medication administration records (MARs) were up to date. The deputy manager told us they worked two days a week supernumerary to the staff numbers which allowed them to ensure the medication systems were in place and peoples' medicines were managed safely. This showed us the registered provider had appropriate arrangements in place to manage medicines.

As part of our inspection we looked at how accidents and incidents were recorded and analysed. The manager told us that all incidents were reported on a form by staff and passed to the manager. The manager assessed the circumstances, analysed the incident and sent an accident, incident and near miss report every week to the regional manager, the project manager and to Head Office for further analysis. We looked at a completed accident report, including the actions taken outcome during our inspection.

Staff told us they knew what to do in the event of a fire and we saw the service had equipment in place to assist in the evacuation of people in the event of an emergency. This demonstrated the service had equipment and processes in place to ensure people's safety was maintained in the event of a fire.

Requires Improvement

Is the service effective?

Our findings

We observed the lunchtime meals in both dining areas. Tables were nicely laid out with table cloths, cutlery and condiments. People were offered a choice of two hot meals and two puddings from the menu. One person told us "First time we have had chicken supreme. It's lovely. I want to compliment the chef". Another person told us "The foods nice. We are well fed". We observed one person was given an alternative meal after they told staff they did not want what was on the menu. Tea, coffee and juice were offered throughout the meal. This showed the registered provider was meeting both the nutritional needs and choice of the people who were living at Alwoodleigh.

We looked at three staff files and found staff had completed a comprehensive induction. This included information on health and safety, fire safety, moving and handling, mental capacity and Deprivation of Liberty Safeguards (DoLS). We also saw evidence that all staff had received a recent annual appraisal. Staff told us they had supervision with the new manager and we saw recorded evidence of this during our inspection. This showed the registered provider had a system in place to monitor the performance and development need of staff.

The project manager told us the corporate style of training was to be changed in March 2015 to a blended learning system. They explained that staff would do their theory 'on line' followed by practical's and workshops with a training executive. The training executives would observe practice to ensure staff had understood the learning. They added, this style of learning was aimed at ensuring staff had both the knowledge and the skills to provide support to meet people's needs. They also told us that some training was out of date but they were waiting for this new style of training to be implemented before staff would have their training refreshed.

The home had a system to record the training staff had received and when training needed to be refreshed. When we looked at the registered provider's training spreadsheet we saw that not all staff training was up to date. In particular, safeguarding, dementia awareness and medication observations. Of the staff listed on the spreadsheet who were identified as requiring safeguarding and dementia awareness training, half of the staff were not up to date with this training. We raised this with the manager who told us this would be addressed once the new style of training was implemented in March 2015.

We also saw that all seven staff who were listed as requiring medication observations needed their competence rechecking. This meant that although we did not observe any practice that was of concern relating to medication, the registered provider did not have the evidence that staff had been provided with opportunity to gain the knowledge and skills in these areas.

The manager told us they had organised additional training for staff which was not listed on the spreadsheet. For example, their pharmacy supplier was booked to provide training on medicines management and a dietician and optician were also booked. This meant training in respect of medicines management was planned to ensure that staff have the skills to provide good quality care.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The manager told us there were no people staying at Alwoodleigh during our inspection who were subject to a DoLS authorisation.

We saw from the registered provider's training matrix, all staff had received training in mental capacity and DoLS and were up to date in line with the requirements of the registered provider's training policy. However, the policy file contained an out of date DoLS policy which did not reflect recent changes to case law. We mentioned this to the manager who rectified this immediately with the up to date policy and told us that they would ensure staff had the up to date information.

We saw information in people's care plans with regard to their capacity to make decisions and decisions made in their best interests if they lacked capacity. One senior member of staff told us "We do the assessments for mental capacity. If they have capacity, they can make their own decisions. If they lack capacity, we always check if there is a Lasting Power of Attorney and we keep a copy in the file. We make best interest decisions with the GP, Home

Requires Improvement

Is the service effective?

Manager, the nurses and the Community Psychiatric nurses". This showed us this staff member had a good understanding of the Mental Capacity Act and what actions to take if someone lacked capacity.

We saw evidence in people's care records that they had access to other healthcare professionals including G.P, occupational therapy, community psychiatric nurse, dietician and chiropodist. For example, we saw one person's records detailed they struggled with cutlery and holding a cup and had been referred to the occupational therapist for an assessment to try to maximise their independence in this activity. This showed people using the service received additional support when required for meeting their care and wellbeing.

We asked the manager about opportunities for volunteers to come to Alwoodleigh and they told us they had three student volunteers in the pipeline and were waiting for a start date following recruitment checks. These volunteers would help with activities including 1:1 sessions for people who lived at Alwoodleigh.

We observed the front door was not easily accessible for those with mobility difficulties due to the steep slope. The manager told us this has been raised with the registered provider who was looking at alternative wheelchair access at the side of the building. The manager also told us Alwoodleigh was due to start a phase of renovations imminently and that it had been recognised that improvements were required to the décor.

Good

Is the service caring?

Our findings

People we spoke with made many positive comments about the care provided at Alwoodleigh. One person told us “The girls look after me well, they speak nicely”. Another person told us; “Never any problem, nice and friendly, nothing is a big deal to them.”

Throughout our inspection we saw people were treated with respect and in a caring and kind way. The staff were friendly, patient and discreet when providing support to people. We saw staff took time to speak with people as they supported them. For example, we observed two people being hoisted to transfer and staff offered reassurance and explanations to reduce their anxiety.

In the main dining area we saw how gentle, kind and attentive the two care staff on duty were while supporting people who were having lunch. One person commented that the carer was ‘fantastic’.

We spoke with one relative who told us the care staff were ‘Attentive and courteous’. They also told us that their relative was always clean and comfortable and that they checked details such as finger nails when they visited , which were always clean. They said “Nothing’s been wrong. I am really pleased”. All the staff we spoke with said they thought people were well cared for.

Throughout the day we saw people’s privacy and dignity was maintained. Staff told us they did this by closing doors when undertaking care, closing curtains and covering people with a towel. One member of staff said “ I treat people as I want to be treated. If you can’t do that then why are you in this job”. They said they would challenge their colleagues if they observed any poor practice and would also report their concerns to a senior person in the home.

We saw details in care records which evidenced people had been referred on to occupational therapy, podiatry, and physiotherapy where appropriate to improve independence around mobility, eating and drinking.

Families we spoke with told us they were able to visit their relatives whenever they wanted. We were told that people could stay with their relatives during the night if the person was nearing the end of their life. This ensured that those people and their relatives were treated with compassion at this time.

We observed one person’s activities record had been left out in view of residents and relatives in the activities room. We brought this to the attention of the manager as this information was not held confidentially. We also observed that the lack of a nurses’ room on the first floor landing meant that it was difficult to keep people’s conversations confidential. Staff told us there was a proposal to change one of the bathrooms on the first floor to a nurses’ office which could also be used as a treatment room by the visiting professionals.

Requires Improvement

Is the service responsive?

Our findings

People had their needs assessed prior to moving into Alwoodleigh. We saw pre-admission assessment's in four of the five care plans we looked at. Information was person centred in all the files we viewed and people's likes and dislikes were recorded. Nutrition and hydration assessments and weight recordings were consistently kept in the files we viewed where problems had been identified. This showed us the registered provider had an effective system in place to ensure nutritional and hydrations needs were met.

Whilst we found care plans were individual to people's needs, and some were very detailed, we found they were not always fully completed. For example, we saw in one person's care plan, the life history section was blank so it would be difficult to tailor care to meet the persons needs based on past life experiences, preferences and previous choices. . Yet we saw another person's life history had been completed in great detail giving insight into their preferences and choices.

In one person's care plan it was recorded they were to be nursed in bed. There was no rationale recorded as to the reason for this. We discussed this with the manager who told us the person had advanced dementia and had been at high risk of falls when admitted to the home from hospital a few days earlier. They told us they intended to refer to the therapy services to assess whether they could sit out in a chair to enable the person to sit in the communal areas. This was not recorded in their notes. This meant this person was isolated in their bedroom without stimulation for a large part of the day.

Daily logs were not completed fully and were task focussed rather than person centred. It was not clear from the daily logs what care had been provided. One record stated "Had supper, went to bed. Asleep when I went with medication so declined". This did not state what time this had occurred, nor was it accurate in stating the medication had been declined, as the person had been asleep so could not have declined the medication.

This demonstrated a failure to protect people against the risks of unsafe or inappropriate care because up to date and accurate records had not been maintained. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation17 (2)d of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had three communal areas and people could choose where they spent their time. People who live at the home told us there were not enough activities on offer. Activities were not recorded in people's daily logs so it was difficult to determine what people had participated in during the day. One person told us, "I go to bed between 4 and 5 pm as there is nothing to do here at night". One relative told us "I would like to see more done. Too much time sat watching television". Yet another person told us "It's good here, like home. I can watch T.V. It's marvellous."

The manager told us there was an activities coordinator for 30 hours each week who planned the week's activities. At other times, the carers engaged with people at the home. The activities coordinator had an activity file where they recorded the activities people had been part of. This evidenced that some people had not undertaken any activities for almost one month. We saw these had been 1:1 sessions, although no further detail had been recorded. We did not see evidence that activities were tailored to individual people or were meaningful to the people living at the home.

We observed that call bells were not always answered in a timely fashion. We asked the manager if there was a way of auditing the call answer times, and were told that it was not possible with the current system. The manager told us they had requested a new system. This meant we were unable to check if staff were consistently unable to respond to people's call bells in a timely manner.

The Care Quality Commission had received one complaint about the service shortly before we carried out the inspection which told us that a concern had been raised but no formal response had been received regarding the issues raised. We talked to the manager about this complaint. . They told us they had not recognised this as a complaint and had therefore not initiated the registered provider's complaints procedure. However, during our inspection this information was passed to the project manager who has since commenced a thorough investigation and has concluded the formal complaints process.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the manager of the service had been in post for seven months and was awaiting registration with the Care Quality Commission. We asked the manager what their vision for the home was and they told us "To give the best care possible. I want people to know about Alwoodleigh; to invite the community in and to get the residents out into the community". The manager told us that Alwoodleigh "had a very good bunch of staff". They told us the biggest challenge since starting in post had been to share his vision with the staff but that staff were now on board with this.

We spoke with the manager about how they monitored the quality of the service they provided. They told us they completed a daily walk around of the home each morning which enabled them to assess and monitor the service. They told us that they came in one Saturday and one Sunday a month so that they could ensure the service ran effectively at a weekend. The manager told us they sought the views of relatives and people who used the service at a relative and residents meeting held every other month and we saw the minutes of the latest meeting.. The manager also told us a monthly newsletter was written by the activities coordinator which detailed forthcoming trips. People who lived in the home, their visitors and staff said they would be confident speaking to the manager if they had concerns about the service.

The manager told us they held a team meeting every other month to keep staff informed regarding the service. The last meeting was held in September 2014 with the next one planned for February 2015. We saw minutes of the meeting held in September 2014 which discussed topics such as residents care survey results, staff satisfaction survey results, supervision, appraisals, moving and handling and results of the latest registered provider visit. They had also discussed the feedback from a Healthwatch 'Enter and View' visit.

We saw the registered provider completed a quality monitoring report every month and undertook a thorough audit of the service provided. This included an audit of the environment, medicines, care plans, the kitchen and maintenance files. Any actions required were passed to the manager to complete. We saw an example of completed action ' to ensure correct weights were recorded on the daily air mattress check sheets and mattresses set to the correct weight setting'. We audited the maintenance files during our inspection and found that these were up to date including an audit of the window openers which had taken place a week before our inspection.

We saw that action had not been taken to improve care recording even though the registered provider's audit of December 2014 had noted incomplete case records. However, the manager had made some changes between our two visits to improve case recording following their own audit of care plans using the registered provider's audit tool. The manager told us the deputy manager would assist with care plan audits in the future they would ensure that 10 % were audited each month. They said this would ensure issues were reported and resolved speedily and to ensure standards of recording were improved.

Systems for ensuring staff had the skills and knowledge to meet people's needs were not always in place. For example, there was no robust monitoring of staff training needs and the system for monitoring supervision sessions required improvement. We found that all supervisions had been completed, but records had been archived as soon as supervision had taken place which meant that actions from one supervision to the next could be missed. We discussed this with the manager who had developed a system to improve this by our second inspection day. This would ensure actions and outcomes from staff supervisions are completed between sessions

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 18 HSCA (RA) Regulations 2014 Staffing This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was insufficient numbers of suitably qualified staff to meet the needs of people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation17 (2) c of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Up to date and accurate records had not been maintained.