SHC Clemsfold Group Limited

Woodhurst Lodge

Inspection report

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Ratings

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

Overall summary

The inspection took place on 19 May 2015 and was an unannounced inspection.

Woodhurst Lodge provides accommodation and nursing care for up to 10 people. The home is purpose built and well-equipped. It caters for people with long-term health needs including neurological conditions and acquired brain injury. At the time of our visit there were nine people living at the service.

The service has 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.

People told us that they were happy living at Woodhurst Lodge. They enjoyed the company of staff and received support in accordance with their individual wishes and preferences. In recent months the home had been

Summary of findings

without an activity coordinator or driver. Although provision had been made for people who wished to attend specific events, there had been fewer activities and outings on offer.

Staff had received training in neurological conditions and felt equipped to deliver support to the people living at Woodhurst Lodge. Staff spoke highly of the training offered by the provider and were encouraged to undertake additional qualifications. There was a system of regular supervision and appraisal to support staff in their professional development. Staff felt supported and were able to speak freely with the registered manager if they had suggestions or concerns.

There was an open and friendly atmosphere at the home. People appeared relaxed and visitors were warmly welcomed. Relatives spoke of the staff skill in understanding people's non-verbal communication and anticipating their needs. People had been involved in planning their care and support and were involved in decisions relating to their care and treatment. Staff understood how people's capacity should be considered and had taken steps to ensure that people's rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

There were enough staff on duty to meet people's needs and to keep them safe. Risks to people's safety were assessed and reviewed. Any accidents or incidents were recorded and reviewed in order to minimise the risk in future. Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse. People received their medicines safely and at the right time.

People received a choice of food and specific requests were cheerfully accommodated. Staff monitored people's food and fluid intake to ensure that they received balanced nutrition and enough to drink.

Staff were quick to respond to changes in people's needs and the service worked collaboratively with external healthcare professionals. Prompt action was taken to ensure that people received appropriate support.

The registered manager had a system to monitor and review the quality of care delivered and was supported by monthly visits from a representative of the provider. In addition, external audits of the service had been commissioned by the provider. The registered manager received regular feedback from people, their relatives, staff and visitors about the running and quality of the service. This included direct feedback and regular meetings. Where improvements had been identified, action plans were in place and used effectively.

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?
The service was safe.

People said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

Staff numbers were sufficient to meet people's needs safely.

Risk assessments were in place and regularly reviewed to ensure people were protected from harm.

Medicines were stored, administered and disposed of safely.

Good

Is the service effective?
The service was effective.

Staff were knowledgeable about people's care needs. They had attended training and received regular supervision and appraisal.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act 2005.

People were offered a choice of food and drink and supported to maintain good health.

People had access to healthcare professionals and the service collaborated effectively with them.

Good

Is the service caring?
The service was caring.

People received care from staff who knew them well and understood their preferences.

People were involved in making decisions relating to their care and staff were skilled at understanding their communication.

People were treated with dignity and respect

Good

Is the service responsive?
The service was mostly responsive.

People received personalised care that met their needs.

Activities and outings were available on request but activity provision had been reduced due to vacancies for an activity coordinator and driver.

People, their representatives and staff were able to share their experiences and any concerns which had been responded to promptly.

Requires Improvement

Summary of findings

Is the service well-led?

Good

The service was well-led.

The culture of the service was open. People and staff felt able to share ideas or concerns with the management.

Staff were clear on their responsibilities and told us they were listened to.

The provider and registered manager used a series of audits to monitor the delivery of care that people received and to make improvements.

Woodhurst Lodge

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 May 2015 and was unannounced.

One inspector and an expert by experience in neurological conditions undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed 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 reviewed notifications received from the registered manager before the inspection. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We observed care and spoke with people, their relatives and staff. 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 looked at care records for three people , four staff files, staff training and supervision records, four staff recruitment records, medicines administration records (MAR), monitoring records for food, fluid and weights, accident and incident records, staff handover records, activity records, complaints, audits, minutes of meetings and staff rotas.

During our inspection, we spoke with three people who used the service, two relatives, the registered manager, one registered nurse, one overseas nurse who was registering to practice in the UK, two carers, one agency carer, the driver, the chef and three representatives of the provider. Following the inspection, we spoke with a third relative by telephone and contacted professionals to ask for their views and experiences. These included a specialist nurse and a dietician. They consented to share their views in this report.

This was the first inspection of Woodhurst Lodge since there had been a change in the provider's registration in October 2014.

Good

Is the service safe?

Our findings

People told us that they felt safe at Woodhurst Lodge. Staff had attended training in safeguarding adults at risk. Refresher training dates were also advertised in the home. Staff were able to speak about the different types of abuse and described the action they would take to protect people if they suspected they had been harmed or were at risk of harm. One carer told us, "I'd go straight to the manager, she does listen". Staff were also aware of other agencies they could contact if they felt further investigation or action was necessary.

Risks to people's health, safety and welfare were assessed as part of a person's admission to the home. Detailed risk assessments were in place and included guidance for staff on how to mitigate the risk. We examined examples of risk assessments for moving and handling, travelling in the minibus and for specific clinical needs such as catheter, gastrostomy and tracheostomy care. Where monitoring was required, for example bowel monitoring to reduce the risk of constipation, this was in place and used effectively. Where accidents and incidents had occurred, these were recorded and analysed so that action could be taken to reduce the risk of future occurrences. Actions taken included referrals to other professionals such as the physiotherapist, the ordering of specialised equipment and supervision of individual staff members. We found that risks were assessed and kept under review in order to promote people's safety.

There were enough staff to meet people's needs safely. People told us staff were available when they wished to be assisted. One said, "Staff help when I want them". Another told us that they never needed to use the call bell because staff checked on them. We observed that staff supported people in a relaxed manner and took time to engage with them. A nurse told us, "It's busy but manageable". The registered manager explained that there had been some vacancies but she had recently recruited four new staff, including an activity coordinator and a driver for the home's minibus. These staff members were due to start in June 2015. To meet the shortfall in nursing and care staff numbers, agency staff had been used. Staff told us that generally the same agency carers and nurses worked in the home. One said, "There are some of them (agency staff) that are like permanent staff". This helped to promote continuity of care for people. Staff numbers included one to one support for some people in order to meet their needs. Staff told us that the registered manager, also a registered nurse , worked with them if needed, or would accompany people to appointments so that sufficient staff remained in the home. In addition to nursing and care staff, the home employed kitchen, housekeeping, maintenance and administration staff. This meant that nursing and care staff were able to focus on supporting people.

Staff recruitment practices were robust. Staff records showed that, before new members of staff were allowed to start work at the service, checks were made on their previous employment history and with the Disclosure and Barring Service. In addition, two references were obtained from current and past employers. These checks helped to ensure that new staff were safe to work in a care setting.

People received their medicines safely. We observed part of the medicines round during lunchtime. The nurse provided clear information for people regarding their medicines and administered them in accordance with the instructions from the prescribing GP. Records included details as to whether people took their medicine orally or via their gastrostomy tube. Guidance was available for 'as needed' medicines and, when given, staff had noted the reason for administration. Medicines, including controlled drugs, were stored safely, administered and recorded in accordance with legislation and pharmaceutical guidelines. Staff told us that if they spotted a gap they raised it immediately with the nurse who had been on duty. Ointments and creams were dated when opened to ensure that they remained effective and were stored in line with the manufacturer's recommendations. Records for the disposal of medicines were complete and up-to-date.

Good

Is the service effective?

Our findings

People spoke highly of the staff. Staff told us they felt they had the skills to support people at Woodhurst Lodge. They had attended training, including specific training regarding neurological conditions. They told us that this helped them to understand and support people. One said, "I had neurological training so that I can really understand it". Another told us, "They train staff so we are able to cope with whatever. I'm proud of Sussex Healthcare for that". Following a classroom-based induction run by the provider, staff attended training updates including moving and handling, fire, safeguarding, infection control and mental capacity. The provider had identified through audits that some staff had not attended refresher training at the annual frequency stipulated in their policy. This was being addressed by the registered manager. A range of additional courses, such as in Huntington's disease and bladder and bowel awareness, were on offer and had been attended by some staff. Staff were encouraged and supported to complete diplomas in health and social care.

Nurses told us that they were able to keep their skills up to date. One told us, "If there are any changes, such as to a procedure, they circulate information around the home". They also said,

"I've done venepuncture training and I'm booked in again to update my catheterisation training". A nurse working towards their registration with the professional body in the UK told us, "We received lectures at Boldings (the Provider's training academy). There was 20 days protected learning but we did more, around 35 days". An external specialist nurse told us that they had provided training to staff at Woodhurst Lodge on a particular condition. They told us, "I provided training on the disease which they all showed up to" and said, "My client is not easy to manage and it has been brilliant. The medical care is good".

Staff told us that they felt supported in their work and were able to ask for additional support or training if required. One nurse told us, "If you need something, even from the head office they will come down and help you". Staff received regular supervision and an annual appraisal. Part of the supervision was a check on competency. For nurses, this included in medicines administration, dressings and catheterisation. In addition to the planned supervision, we noted examples of ad-hoc supervision sessions, for example after an incident of poor practice or missing documentation. This helped to ensure that staff received guidance and were encouraged to provide effective support to people.

During our visit we observed that staff involved people in decisions and respected their choices. Staff understood the requirements of the Mental Capacity Act (2005) and put this into practice. For example, staff followed the presumption that people had capacity to consent by asking if they wanted assistance and waiting for a response before acting on their wishes. Advocacy information was displayed in the home. An advocate can represent a person when specific decisions need to be made such as about medical treatment or accommodation. Where people did not have capacity to make specific decisions, such regarding their nutritional needs, best interest meetings involving representatives of the person, staff and the GP had been held.

The provider was aware of a revised test for deprivation of liberty following a ruling by the Supreme Court in March 2014 and had taken action in respect of this. A deprivation of liberty occurs when 'the person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements'. This requires the provider to apply to the local authority for Deprivation of Liberty (DoLS) authorisation. We saw that applications had been submitted. The home had not yet received decisions on these applications from the local authority.

People were enthusiastic about the food and had a good rapport with the chef. One said, "The chef asks what you want. I have my meals in my room. Snacks are there if you ask". At lunchtime we observed a variety of meals were served, including a specific request for a burger and another for a salad. Where appropriate, staff encouraged and supported people to eat. The chef told us, "There are only 10 people, I can make different dishes, it's no problem". People were asked for the feedback on the food served. This was reviewed by the chef. Specific requests, such as croissants for breakfast, had been accommodated.

The chef had attended training in special diets and providing fortified food. Information on people's dietary needs was included in their care plans. In one we read, 'I have my food liquidised and fed to me with a plastic spoon'. The information for staff included guidance on how to support people, including which side to stand on and in

Good

Is the service effective?

one case touch cues to help the person anticipate when the food was being offered to them. People's weight was checked monthly and staff assessed each person's risk of malnutrition. Where appropriate the service had been in contact with external healthcare professionals and nutritional supplements had been prescribed. Where people were at risk of dehydration, fluid balance charts were used. These had been used effectively to monitor people's fluid intake.

People had access to healthcare professionals and the service worked in collaboration with them to ensure people's needs were met. One person told us, "The physio comes regularly. The GP visits once a week". The provider employed their own physiotherapy staff. A relative said, "Physio is nice. We all like using the multi-sensory room; we've been invited to go in there with (their relative) which is great". We saw that referrals had been made, including to the occupational therapist, audiology and Ear Nose and Throat (ENT) clinics. A dietician told us, 'At my visits the Home manager is always able to provide me with good information about the health of the service users, and is able to easily provide relevant written evidence to support her views. She is knowledgeable and appears able to use this knowledge to make good decisions about her service users and when to contact me for further advice'.

The home was purpose built by the provider. The registered manager told us, "It's special because it is purpose built and there is enough space both inside and outside". Each room was equipped with an overhead tracking hoist and had direct access to the gardens. There was an assisted, height adjustable bath, a hydrotherapy pool and a sensory room, each equipped with overhead tracking hoists. The adaptation and design of the home meant that people were able to move freely and access its facilities.

Good

Is the service caring?

Our findings

People had developed positive relationships with the staff who supported them. One person told us, "The full time staff are amazing. They know their job and understand what I want. They just do it, I don't have to ask". During our visit we observed people laughing with staff. Staff also provided people with reassurance. As one person was waiting for their lunch, a staff member gently said, "(Other staff member) is bringing your food". The person had not said anything but looked happier following the assurance. The staff member's remark was spontaneous and it was clear that they knew and understood the person well.

Relatives spoke highly of the staff team. One said, "The staff there are wonderful, they do a really good job". Another told us, "We come every day so we see how things are. They make us feel welcome". The home included a flat which could be used by relatives. One relative told us that they had been offered the use of the flat when their relative was unwell. They told us that knowing they could be close if needed provided them with a sense of comfort.

Where possible, people had been involved in determining the care that they received. Sections of the care plans were written in an easy-to-read format which included symbols to aid understanding. One person had written their life history and signed their care plans to demonstrate their agreement. As part of the admission assessment people or their representatives had been asked to provide information on the person's preferences. Specific preferences such as, 'daily wet shaving' had been recorded.

Care plans included detailed information on how people communicated. This included verbal and non-verbal communication. For example, we read, 'I can spell what I want to say to you – make the board available if you are having trouble understanding me'. In another we read that a person would, 'smile and vocalise loudly' when happy and 'kick my legs out' when unhappy. One relative told us, "I am very happy with the care he gets. The permanent staff have built up relationships with him, they can read his facial expressions". Each person had a hospital passport in place. A hospital passport helps people to communicate their needs and preferences to doctors, nurses and other healthcare professionals.

Some people used assistive technology. One person was able to operate their light and fan via a remote control. This helped to promote independence. The same person also explained how staff had assisted them to arrange their room, set up their computer, TV, entertainment centre and speakers. The registered manager spoke enthusiastically about the possibilities offered by technology and explained how they were looking at additional functions such as remote opening and closing of the door.

Staff treated people respectfully. They addressed people by their preferred names and gave them time to consider and respond to questions. A dietician involved with the service told us, 'During my visits the staff always seem attentive and caring towards their service users'. Each room was equipped with an ensuite wet room. This meant that people could wash and dress in the privacy of their rooms. Care plans included specific instructions for staff. In one we read, 'I like to have my privacy when I am on the toilet. I will ring for assistance once I am finished'.

Requires Improvement

Is the service responsive?

Our findings

Some people were unhappy about the change in activity provision. The driver had left employment at the start of the year and the activity coordinator had left approximately one month before our visit. This had an impact on the opportunities for people to be involved in activities and to spend time out in the community. One person told us, "The activities lady left as well (as the driver). She used to be the one arranging things. Now she's gone there's a gap". A relative said, "Since (activity coordinator) has been gone there don't seem to be any activities, it's just the television. (My relative) doesn't really go anywhere". We spoke with staff about the activities. One told us, "Everyone is now trying to cover outings, which is difficult with no driver as well". They explained that they used drivers from other services run by the provider and booked taxis if that was not possible.

In the period since the activity coordinator left, there were very few records of activities that had taken place in the home. People had individual activity schedules but these did not accurately reflect the opportunities that were available. For example, some people had use of the sensory room down for Tuesdays. We were told that this was done with the physiotherapist but that they did not visit on this day. The registered manager compiled a list of outings that had taken place from the home's diary. Outings included visits to a local park, shopping, the cinema, the pub, a zoo and for one person horse carriage riding. One person told us, "It's not easy. They will book other drivers for hospital appointments, but opportunities for visits not offered like they were". For people who were unable to go out, it was unclear what opportunities or stimulation had been offered due to a lack of records.

On the day of our visit, the television was on in the dining/activity room during the day. We observed a staff member playing cards with one person. We did not observe any other opportunities for people to be involved in activities. One staff member said, "I do take some people out in the grounds, to the pond etc., but only when there's time". The registered manager had recruited a new driver and activity coordinator who were due to start in post. She told us, "We're almost there with staffing, it has just been a difficult time". We found that during this period there had been little planning or pro-active support for people to enjoy creative, relaxing and stimulating pastimes. People were able to request support for activities or trips out but opportunities were not being offered and looked forward to.

People were happy with the care they received. One person said, "The staff are very kind. They get me up when I want. I get up early and have a shower every day at the time I want". Each person had a named nurse and a keyworker. When a person moved to the home they and their relatives were asked for information about their experiences and interests. This was added to by staff as they got to know people better. Care plans included details as to people's needs and preferences, including on nutrition, moving and handling and sleeping. Staff reviewed people's needs on a monthly basis, or sooner if needed. Where changes had occurred this was clearly recorded. We read updates including, 'Can sit up, roll independently whilst in bed' and, 'feeding regime changed after dietician review'. Changes were communicated to staff during handover meetings. In the summary for one person we read, 'Sounding chesty, informed the GP, now on medication'. One staff member told us, "They (the care plans) are useful. They are updated according to the change of their condition".

People were invited to share their views and suggestions with the registered manager and staff. Dates of residents' meetings were displayed. In the May meeting there had been discussions about activities and people were looking forward to a summer barbeque. Events were also held for relatives and friends. In March 2015 a, 'Cheese and wine communication afternoon' had been held. The registered manager had a record of the conversations with relatives and actions had been noted. Many actions had already been completed, for example one person's computer had been mended and a second person's needs had been reviewed with the physiotherapist.

Some people had raised concerns with staff. These were recorded and addressed. One person had indicated that they did not wish staff to use a slide sheet when helping them to change position. Staff had spoken with the registered manager who then met with the person on a one to one basis to discuss their reservations. Staff told us that following this meeting with the registered manager the person had been willing to use the slide sheet.

The provider had a complaints policy which was clearly displayed in the home. We saw that the few complaints received had been dealt with appropriately and in

Requires Improvement

Is the service responsive?

accordance with the timescales set out in the policy. One person had complained that they did not like the way night staff supported them to brush their teeth. The person was encouraged to write down how they liked to be assisted. These guidelines were shared with all staff and the problem was resolved. One relative said, “We’ve had a couple of blips but they did sort them out for us”. Another relative who had complained told us, “The area manager rang me and dealt with it very quickly. They took it seriously”.

Good

Is the service well-led?

Our findings

People told us that they liked the home. One said, "It's very nice". A relative said, "It's a happy home. Whenever we go up there it is all open. The staff always welcome us and offer tea and cake". An agency staff member said, "I'm always happy when I'm sent here for a shift".

The registered manager was available and willing to listen to people and relatives. A relative said, "We've not had any problems. If we did, we would speak to (the registered manager). She's always ready to listen". Staff were encouraged to speak up if they had any concerns. There was a whistleblowing policy in place and staff told us that they felt able to approach the registered manager. One said, "We work as a team. We always say what we want, and we have a suggestions box". We noted that following some anonymous concerns, a staff meeting had been called. The registered manager discussed the letter openly with staff and reminded them that she has an, 'open door policy'. One carer told us, "On the occasions I approached her (the registered manager) she did something about it".

Staff spoke positively about the registered manager. One said, "She has been helpful and supportive to me". Another told us, "She will always pick up the phone, no matter what time you call". There was a system of shift handover and regular staff meetings, including specific trained nurse meetings. This provided staff and management with a system of communication so people received safe and effective care. A specialist nurse who visited the service told us, "Every time I ring I get a full report. It's very well organised and very well managed". The registered manager was furthering her knowledge through study at a local university into long term, non-malignant conditions. She told us, "I am supported. They (representatives of the provider) are always there to help you".

The registered manager and provider used a variety of audits and checks to monitor the quality of the service. The registered manager worked occasional shifts as a nurse in the home. She told us,

"Whenever I work the floor, I pick up lots of things". She also acted as a mentor for nurses working towards their UK registration. This meant that she used the processes in place and could see where improvements were needed. The registered manager completed a weekly medicines audit and had appointed a member of staff to be responsible for infection control. This staff member attended meetings run by the provider and updated staff in the home on good practice and any new guidelines. One person told us that equipment was sometimes stored in the bathroom. We noted that the registered manager had raised this as a concern and had made a recommendation for additional storage space as part of her annual review.

A representative of the provider carried out monthly visits at the home. Action plans were in place and were reviewed on each visit. We saw that actions were usually completed, for example the summer menu was noted as an action for March. This had been completed by April. An internal audit had been carried out in January 2015, a full external audit commissioned by the provider in March 2015 and a specific health and safety audit in October 2014. These audits had looked at the service, made recommendations and set actions. The action plans demonstrated that the registered manager had taken note of the recommendations and taken steps to improve the quality and safety of the service that people received.