Care Quality Commission

Crosscrown Limited

Woodville House

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?	Good
Is the service well-led?	Good

Overall summary

We inspected this service on 23September 2015. The inspection was unannounced. At our previous inspection in September 2013, the service was meeting the regulations.

There was a registered manager in post. 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 service provides accommodation and personal care for up to 15 older people who may be living with dementia. On the day of our inspection, 11 people lived at the home.

The provider's policies and procedures to minimise risks to people's safety were understood by staff. Staff understood their responsibilities to protect people from harm and were supported to raise any concerns. The registered manager assessed risks to people's health and welfare and people's care plans minimised the identified risks.

Summary of findings

There were enough staff on duty to meet people's physical and social needs. The registered manager checked staff's suitability to provide care during the recruitment process.

The premises were maintained and regularly checked to ensure risks to people's safety were minimised. The provider's medicines policy included training staff and checking that people received their medicines as prescribed, to ensure people's medicines were administered safely.

People received care from staff who had the skills, experience to meet their needs effectively. Staff understood people's needs and abilities because they read the care plans and shadowed experienced staff until they knew people well. Staff were supported and encouraged to reflect on their practice and to develop their skills and knowledge, which improved people's experience of care.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). No one was subject to a DoLS at the time of our inspection. The manager had checked that the care and support people received did not amount to a deprivation of their liberty. For people with complex needs, records showed that their families and other health professionals were involved in making decisions in their best interests.

Risks to people's nutrition were minimised because staff knew about people's individual dietary needs and preferences. People were offered a choice of foods and were supported to eat and drink according to their needs.

Staff were attentive to people's moods and behaviours and understood how to minimise their anxiety. People were encouraged and supported to engage in activities and events that gave them an opportunity to socialise, which lifted their mood. Staff ensured people obtained advice and support from other health professionals to maintain and improve their health or when their needs changed.

People and their relatives were involved in planning and agreeing how they were cared for and supported. Care was planned to meet people's individual needs, abilities and preferences and care plans were regularly reviewed.

People and relatives told us care staff were kind and respected their privacy and dignity. People were confident any concerns would be listened to and action taken to resolve any issues.

The staff and management shared common values about the purpose of the service. People were supported and encouraged to live as independently as possible, according to their needs and abilities.

The provider's quality monitoring system included regular checks of people's care plans, medicine administration and staff's practice. Accidents, incidents, falls and complaints were investigated and actions taken to minimise the risks of a re-occurrence.

People who lived at the home were encouraged to share their opinions about the quality of the service. The provider and manager took account of people's opinions to make sure planned improvements focused on people's experience.

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. Staff understood their responsibilities to protect people from the risk of abuse. Risks to people's individual health and wellbeing were identified and care was planned to minimise the risks. The registered manager checked staff's suitability for their role before they started working at the home. Medicines were stored, administered and managed safely.

Good

Is the service effective?
The service was effective. People were cared for and supported by staff who had relevant training and skills. Staff understood their responsibilities in relation to the Mental Capacity Act 2005. The registered manager understood their legal obligations under the Deprivation of Liberty Safeguards. People's cultural, nutritional and specialist dietary needs were taken into account in menu planning and choices. People were referred to other healthcare services when their health needs changed.

Good

Is the service caring?
The service was caring. Staff were kind and compassionate towards people. Staff knew people well and respected their privacy and dignity. Staff promoted people's independence, by encouraging them to make their own decisions.

Good

Is the service responsive?
The service was responsive. People and their families were involved in planning how they were cared for and supported. Staff understood people's preferences, likes and dislikes. People were encouraged to engage in events and activities of their choice, which promoted their well-being. People were confident any complaints would be dealt with promptly.

Good

Is the service well-led?
The service was well led. People were encouraged to share their opinions about the quality of the service which ensured planned improvements focused on people's experiences. The provider's quality monitoring system included checking people received an effective, good quality service that they were satisfied with.

Good

Woodville House

Detailed findings

Background to this inspection

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

The inspection took place on 23 September 2015 and was unannounced. The inspection was undertaken by one inspector.

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 also reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with four people who lived at the home and two relatives. We spoke with the registered manager, two care staff, the cook and the activities coordinator. We observed care and support being delivered in communal areas and we observed how people were supported at lunch time.

Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us to assess whether people's needs were appropriately met and identify if they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We reviewed three people's care plans and daily records to see how their care and treatment was planned and delivered. We checked whether staff were recruited safely and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Good

Is the service safe?

Our findings

People and relatives told us the service was good and they felt safe. Relatives told us they were confident their relations were safe at the home. We saw people were relaxed and chatted easily with staff and moved confidently around the home, which showed they felt safe.

Staff knew and understood their responsibilities to keep people safe and protect them from harm. All the staff told us they had safeguarding training. The policy and procedure for making a referral to the local safeguarding team was displayed in the hallway, where staff and visitors could read it. Care staff told us they felt encouraged by the whistleblowing policy to raise any concerns. Care staff told us, "I would report any concerns to the senior. They listen," and "I have never seen anything of concern here." The registered manager had not needed to make any referrals to the local safeguarding team.

The provider's policy for managing risks included assessments of people's individual risks. In the three care plans we looked at, we saw the registered manager assessed risks to people's health, physical and emotional wellbeing. Where risks were identified, people's care plans described how staff should minimise the identified risks. For example, the manager checked risks to people's mobility, communication and understanding. The care plans described the equipment needed and the actions staff should take to support people safely.

Care staff were knowledgeable about people's individual risks. A member of care staff told us, "[Name] prefers to be in the wheelchair for activities and lunch, and comes to an armchair with a footstool in the afternoon and has cushion boots in bed to relieve pressure." This explanation matched the person's care plan. The care plans showed people's risk assessments were regularly reviewed and updated.

Records showed that the provider's policy for managing risk included regular risk assessments of the premises. Records showed the fire alarm, water and electrical systems were regularly checked and serviced. All staff received health and safety, first aid and fire training to ensure they knew what actions to take in an emergency and care plans included people's personal evacuation plans.

The registered manager had emergency plans for untoward incidents. For example, when the lift had recently broken down, people were invited to move temporarily into another of the provider's homes, to ensure their access to communal areas was not restricted. Once the lift was repaired, people moved back to the home. When the engineers established that the lift would have to be replaced, the provider installed additional stair lifts to all the floors first, to ensure people could maintain their independence during the replacement work. Care staff were confident the risk assessments and interim care plans were effective and safe when people used the stair lift. A member of care staff told us, "We use a moving belt and frame to assist [Name] and [Name] to the stair chair." We saw both named people were supported to access and use the ground floor during our inspection.

Staff recorded incidents, accidents and falls in people's daily records and kept a log for analysis by the registered manager. Records showed staff recorded the person, the location, time, outcome and action taken. Any necessary changes to minimise the risks of a re-occurrence were included in the person's updated care plan.

People and relatives told us there were always enough staff to support them or their relations. Some relatives told us they visited every day, so they would know if their relation's needs were not met. The manager told us they used a dependency needs analysis and considered the layout of the building to determine the level of staff needed. On the day of our inspection, we saw there were enough staff to support everyone according to their physical and emotional needs. Care staff had no concerns about the number of staff on duty.

The provider's recruitment process ensured risks to people's safety were minimised. A member of staff told us, "I had an enhanced DBS check and references. I had to wait four weeks before starting work." The registered manager showed us records of the checks they made of staff suitability before they started working at the home. The manager obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions.

People's medicines were managed and administered safely. One person told us, "I have my own medicines in my room. We did a risk assessment and I have a room key." Care staff told us, apart from one person who was able to manage their medicines independently, only trained staff administered medicines. Medicines were delivered from

Good

Is the service safe?

the pharmacy in blister packs, marked with the name of the person, and were kept in a locked cabinet. There were medicine leaflets for each person so staff knew what each medicine was for.

The pharmacist provided medicines administration records (MAR) for each person, which stated the dosage, frequency and time of day they should be administered. The three medicines administration records (MAR) we looked at were signed and up to date, which showed people's medicines were administered in accordance with their prescriptions. Care staff checked the amount of medicines in the cabinet at each shift change.

Care staff recorded when medicines were not administered and the reason why not. A member of care staff told us sometimes people living with dementia declined to take their medicines, but they offered them again later, "When they are in a happy moment," and this was usually effective. The member of care staff told us most people could say if they wanted pain relief medicines and they knew from people's behaviour or facial expression, if a person was not able to express themselves verbally. Staff said they could ask a GP's advice if they had any worries about supporting people to control their pain.

Good

Is the service effective?

Our findings

People told us the staff were good and supported them according to their needs and abilities. One person told us, "Staff will support me when I want it." A relative told us, "[Name] is well looked after. They understand her." We saw staff knew people well and supported them appropriately with their physical, emotional and social needs.

People received care from staff who had the skills and knowledge to meet their needs effectively. Care staff told us they had an induction programme, read people's care plans and worked with experienced staff when they started working at the home. A member of care staff told us, "The policy and procedure is in the books to be read during induction. They made sense." Records showed that staff received training that was appropriate to people's needs. Care staff told us, "I had training in safeguarding, dementia and food hygiene" and "Without the training you wouldn't be able to do the job."

Staff told us they felt confident in their practice and were to share their experience across the staff team. One member of care staff told us, "If I saw staff doing something that wasn't right, or wasn't good enough, I would say, 'can you change that'." Records showed staff were encouraged to reflect on their practice and to consider their own professional development at regular one-to-one meetings with their line manager. All the staff had obtained, or were working towards, nationally recognised qualifications in health and social care. The registered manager told us that all the staff had been registered to complete the Care Certificate as part of their induction for new staff and as a refresher for long term staff.

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) set out the requirements that ensure, where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. Relatives told us they had been involved in discussions about how their relations were care for and supported. The provider had trained the staff in understanding the requirements of the Mental Capacity Act. The guidance for staff in people's care plans included 'prompting' and 'encouraging' people, to make sure people were free to make their own decisions. Staff asked people how they wanted to be cared for and supported. Records of care provided showed that people were able to accept or decline staff's support.

The MCA and DoLS require providers to submit applications to a supervisory body for authority to deprive a person of their liberty. The registered manager understood their responsibility to comply with the requirements of the Act. In the care plans we looked at, we saw the manager completed a DoLS assessment to make sure the care and support that was planned did not amount to a

deprivation of a person's liberty. No one was deprived of their liberty or was under a DoLS at the time of our inspection.

People and relatives told us the food was very good and they always had a choice. People said, "I liked the lunch" and "I had a nice pudding." One relative told us, "I visit every day and we have lunch together." Another relative told us their relation was offered meals that met their specific cultural needs. We saw a member of staff had a conversation with everyone individually in the morning to ask what they would like for lunch that day. The cook told us there was a four week rolling menu that changed with the season and was varied according to people's preferences, moods and suggestions. They said, "Likes and dislikes are discussed at care planning and added to the kitchen folder. I give people time to settle in then go in and chat and review the initial food plan." We saw the cook kept a folder in the kitchen which described people's dietary requirements, likes and dislikes and preferred snacks and noted whether care staff should assist or prompt people to eat.

At lunchtime we saw there were enough staff to support people if they needed assistance. The dining tables were laid with cloths, napkins and glasses and people had a choice of drinks. The meal was unhurried and staff were attentive and made sure the people had time to savour and enjoy their food. We saw people were supported to eat in accordance with advice from other health professionals, such as dieticians and the speech and language therapists. One person had thickened drinks to minimise the risk of choking and another person had a plate guard to assist them to eat. The cook told us this was 'better than being assisted' as it promoted choice and independence.

The care plans we looked at included an assessment of the person's nutritional risks. For one person who was assessed as at risk of poor nutrition, we saw their care plan included

monitoring their weight and their food and fluid intake. Care staff recorded the person's dietary intake after lunch

Good

Is the service effective?

and we heard them share information about the person's appetite at handover. The cook told us they supported people and their relatives with the important events in their lives, such as birthdays and funeral wakes. The cook told us, "There is no constraint on the budget. We buy whatever we need."

Risks to people's health and nutrition were minimised. Records showed the cook checked the fridge and freezer temperatures and the temperature of food supplies on arrival and before meals were served. The kitchen was cleaned according to an agreed schedule and the local environment health officer had awarded the service the top rating of 'five' for hygiene.

Relatives told us their relations were supported to maintain their health. Two relatives told us, "They called the doctor and got a blood test done" and "They noticed when she was looking unwell and did a test and took it to the surgery. She went straight onto antibiotics." Care plans we looked at included records of visits and advice from other health professionals, such as dieticians, GPs and opticians.

Good

Is the service caring?

Our findings

People told us they were happy living at the home. They told us the staff were kind and thoughtful. One person said, “They are all so kind. I was nervous about moving here but it’s lovely.” Relatives told us, “Staff are very nice” and “I can’t speak highly enough of them.” A member of care staff told us, “I am told I am doing a good job by staff and relatives.”

We saw staff treated people with kindness and compassion. People appeared relaxed in staff’s company and staff engaged them in conversations that made people smile. Care staff understood people’s moods and behaviours and supported them with their practical and emotional needs. We saw staff understood people who were not able to communicate verbally and supported them with kindness and compassion. When one person appeared to be agitated, we saw staff offered the person their hands and a comfortable seat, while speaking reassuringly to them. The person’s facial expression and mood changed as they sat down.

A poster in the hallway explained that the provider had signed up to the dementia pledge meaning the employers and staff were trained in dementia awareness. Care plans included a dementia assessment which recorded the person’s current values, beliefs and feelings. This ensured that people were cared for and supported according to how they felt currently, rather than how they had felt at an earlier time in their life.

One person told us they had planned their own care. They told us, “Staff will support me when I want it.” Most people were not able to tell us how they were involved in agreeing their care plan, because of their complex needs. However, the care plans we looked at demonstrated people and their representatives had been asked how they would like to be cared for and supported.

Two relatives told us the care plan discussions meant they could share information about their relation’s life. The care plans included information about the person’s religion, culture, family and significant events. Care staff knew about and respected people’s diverse needs and preferences. They were able to explain how they supported people to maintain their traditions by providing a culturally appropriate diet for one person and ensuring another person was supported to maintain their religious practices.

Two relatives told us they visited every day and always felt welcome. They told us staff enabled them to be involved in their relation’s on-going care and supported them to maintain their involvement in the local community. We saw one person went out with their relative for a walk and another person went out independently. They told us, “I come and go as I please.”

Relatives told us staff treated them and their relations with dignity and respect. A member of care staff told us this meant giving people privacy and, “Closing doors.” We saw staff spoke discretely when offering personal care or assistance. When one person declined staff’s assistance, staff respected their decision, which promoted their independence.

Good

Is the service responsive?

Our findings

People told us they were cared for and supported in the way they wanted. They told us that care staff understood them and knew what they liked and disliked. Relatives told us they were involved in care planning when their relation moved into the home. Relatives told us, "We brought lots of things from home" and "They keep me informed."

Care staff told us they knew about people's preferences, hobbies and interests because they read their care plans and chatted with people. The care plans we looked at included information about people's life history, interests, sociability and communication. Records showed the activities coordinator had one-to-one conversations with each person who lived at the home to find out about their strengths, difficulties, lifestyles and interests. The activities coordinator planed events and pastimes people said they would enjoy, which engaged them physically and intellectually. They told us, "We adapt to each person's abilities. It is not entertainment, but engagement. We chat, interact and improve their day."

There were photos of people engaged in craftwork and attending celebrations along the hallway. During our inspection we saw a group of people playing balloon tennis with foam batons, which generated a lot of smiles and laughter. The activities coordinator told us, "The balloon tennis improves people's moods and flow of energy." After the game, people and their visitors engaged in a quiz in the form of riddles, which made people smile. In between the games, people were singing and tapping in time to some music. A relative told us they enjoyed being around when their relation took part, because them were cheerful afterwards. Another relative told us they would not be able to provide this (engagement) at their home. During the afternoon one person told us, "I enjoyed the sing song."

Records showed people's care plans were regularly reviewed and updated when people's needs changed. Care staff shared information about changes in people's needs during their handover meetings. Care staff told us the information they shared was detailed enough to let them know how people were and whether there were any changes in people's needs and abilities. A member of care staff told us, "I read the notes from the previous shift and we have a handover. I feel informed. We have to know what happens."

Records included information about people's moods, appetites, whether anything was 'unusual' and if visits from other health professionals were booked or had taken place. We saw a two hourly chart staff kept for one person whose behaviour had recently changed. They planned to use the information to identify potential triggers for the changes and to analyse which response by staff was most effective at calming the person.

There was a copy of the provider's complaints policy and procedure in the hallway for anyone to read. None of the people or relatives we spoke with had any complaints about the service. A member of care staff told us, "I have never heard any complaints. I would tell the senior if I did." The registered manager had a file ready to record complaints and the actions taken to resolve them, but no complaints had been received. There were thank you cards and compliments posted on a notice board in the hallway. The compliments reassured the manager that people did not have any complaints about the service.

Good

Is the service well-led?

Our findings

The people and relatives we spoke with were happy with the quality of the service. Relatives told us, "The manager is very nice, and so are the staff" and "The manager, she keeps on top of everything."

People and their relatives were encouraged to share their views of the service. Records showed that the provider invited them to take part in an annual survey and to make suggestions for improvements about the food, mealtimes, support staff, the premises and management. The most recent survey showed that all ten people who had responded were satisfied with the service. People had commented, "Don't have to wait long for staff" and Very good. They always ask how it is."

The registered manager took action in response to people's views of the service. People were invited to meetings to talk about the quality of the service and to make suggestions for improvements. Records showed people liked the activities and would like to have a minibus to go out as a group to farms and parks. The registered manager told us they had shared this suggestion with the provider, because the minibus could be used by all the homes in the provider's group.

The provider's vision and values were clearly expressed in the service user guide. The guide explained the philosophy of care, which included, "Care, love and respect that we would expect members of our own family to receive." Throughout our inspection we saw that staff upheld these values. Staff told us, "It's lovely (at the home). We work as a team, a family team" and "Staff live by the policies."

The registered manager notified of us of incidents and important events, in accordance with their statutory obligations, and demonstrated the skills of good leadership. A member of care staff told us they thought the service was well led because the manager was approachable and proactive. Staff told us, "We have staff meetings and can discuss any concerns" and "I can have a conversation with the manager whenever I like."

Staff told us they had opportunities to discuss their practice and share ideas outside of their daily routine at regular team meetings. Records showed staff were given guidance and reminders about best practice at team meetings. Staff told us, "We talk about changes in people's needs and abilities, training and events" and "The senior or my team tell me if I am doing a good job."

The management structure supported the whole care team to share ideas and keep up to date with the latest practices. The provider was a member of a local association for care home providers, which meant they kept up to date with changes in the industry. The registered manager was also the operations manager for the group and had operational oversight of four other homes, which enabled them to identify and share suggestions for improvements. Training was provided across the group of homes so care staff had opportunities to share ideas with others. The activities co-ordinator told us they would like to meet and exchange ideas with other activities coordinators in the group and would suggest this to the registered manager.

Care plan and people's dependency profiles were regularly reviewed and updated. This meant the manager could regularly check that the number of staff on duty was enough to support people according to their needs and abilities. Care staff told us they had time to fulfil their responsibilities. Care staff told us, for example, when medicines were delivered, the senior had the time, and an appropriate, separate room to check the delivery was complete and accurate without distraction. This meant the provider ensured there were sufficient resources to maintain the quality of the service.

The registered manager analysed accidents, incidents and falls to check staff had taken appropriate action to minimise individual risks and to identify any patterns. No pattern had been identifiable in the month prior to our inspection. For one person who was at risk of falling with no identifiable trigger, the manager had consulted with their GP to check whether any preventative action could be taken, and which ensured the GP was also aware of the frequency of the person's falls, even though no injuries were sustained.

The registered manager followed the provider's monthly audit schedule to check that people received the care they needed. We saw the results of the manager's recent audits of the premises, equipment, infection control measures and medicines. No issues had been identified, which demonstrated the preventative measures in place were effective to minimise risks to people's health and welfare.

Good

Is the service well-led?

The provider took appropriate action to minimise risks to people's health and welfare and provide high quality care though proactive and responsive action. The registered manager told us their plans for improvements included a new therapy room to enhance people's contentment, developing staff, to support a potential promotion and increase in responsibilities, and more regular and frequent meetings for people who lived at the home.