Wotton Rise Nursing Home Limited

Charnwood House Nursing Home

Inspection report

49 Barnwood Road
Gloucester
Gloucestershire
GL2 0SD

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13 November 2018
14 November 2018

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20 December 2018

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

Summary of findings

Overall summary

What is life like using this service:

People told us they felt safe. People were protected from potential abuse and discrimination. Risks to people had been identified and action taken to reduce these. The home was kept clean and measures were in place to reduce risks of infection. Medicines were managed safely and people were given the support they needed to take their medicines. Enough suitably experienced and skilled staff were available to meet people's needs. Staff were recruited safely.

On-going assessments of people's needs ensured people's physical, mental and social needs were understood. People had access to health and social care professionals to support these. People had a choice of food and were provided with the right type of food and drink to meet their health needs. Staff received relevant training to be able to meet people's needs.

The principles of the Mental Capacity Act 2005 (MCA) were applied. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Decisions made on behalf of people were made in their best interests.

Staff were caring and compassionate. They communicated well with people which ensured people's preferences and wishes were understood. People could receive visitors when they chose and the views of people's representatives, where appropriate, were sought and valued. People's diverse cultural and religious preferences were accepted and supported.

Care plans recorded people's needs and gave guidance to staff on how these should be met. Changes to people's care were made where people's abilities, health or risks altered and staff were informed of these daily. Information about people's care and treatment was kept secure and confidential.

Staff supported people to take part in social activities. They provided group and one to one activities, although people told us they would benefit from more activities and meaningful interactions. We have made a recommendation that the service review its current activity provision to ensure it is meeting people's social needs. Community links provided access to, for example, support from local churches. There was a complaints procedure in place and easy access to managers, which ensured concerns and complaints could

reported, investigated and resolved.

Staff were experienced in supporting people at the end of their life. Arrangements were in place to ensure people's end of life wishes were met and a comfortable and dignified death was experienced.

The home had two registered managers. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

A home manager was also employed and collectively, the managers ensured the home ran in such a way which achieved good outcomes for people. Managers shared responsibility for monitoring the quality of the service provided. Audits and other internal checks were completed as part of a quality monitoring process. We were informed, by the registered managers, that actions were taken immediately to address necessary improvements to the service. A record of actions would provide a clear audit trail of how and when improvements to the service are planned and completed and how risks would be managed till improvements were made. We have made a recommendation about the recording of service improvement actions and plans.

All managers were aware of their responsibilities and met these, in relation to the care homes registration with the CQC and in relation to other relevant legislation.

Rating at last inspection:

The last inspection was in June 2016 when the service was rated as 'Good' overall. The service remains 'Good' overall.

Why we inspected:

This was a planned comprehensive inspection based on the rating at the last inspection.

About the service:

Charnwood House is a care home which provides nursing care. It provides care and treatment to people with complex physical needs. Also to people who live with dementia and mental health needs. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered to provide care to 35 people. At the time of the inspection 21 people lived there.

Further information is in the detailed findings below.

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Charnwood House Nursing Home

Detailed findings

Background to this inspection

The 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 checked 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 team:

One inspector and an Expert by Experience completed the inspection on 13 and 14 November 2018. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

This service was selected to be part of our national review, looking at the quality of oral health care support for people living in care homes. The inspection team included a dental inspector who looked in detail at how well the service supported people with their oral health. This includes support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019. The intelligence gathered from this service, with regard to this review, has not been included in this report.

Service and service type:

Charnwood House is a nursing home. It provides care and treatment to predominantly older people who live with complex needs and who require nursing care.

The home had two registered managers. 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.

Notice of inspection:

This inspection was unannounced.

What we did:

Prior to the inspection we reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, for example, allegations of abuse, serious injuries and deaths. We used information the provider sent us in the Provider Information Return to help plan our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the last quality review report (dated October 2017) written by commissioners of the service. We sought feedback from health care professionals who visited the home.

During the inspection, we spoke with seven people who used the service, two relatives and a visitor and asked them about their experience of the care provided. We reviewed the care files of four people, which contained care plans, risk assessments and other relevant care and health information. We reviewed people's medicine administration records and records relating to the Mental Capacity Act 2005. We reviewed a selection of service audits. We requested a copy of the staff training record and a risk assessment and action plan relating to the condition of the carpets. These were forwarded to us as requested.

Good

Is the service safe?

Our findings

People continued to be safe and protected from avoidable harm.

Assessing risk, safety monitoring and management:

- Potential risks, relating to the environment or home's equipment, were identified. The maintenance record showed the immediate action taken to reduce risks associated with perished and ripped areas of carpet to reduce trip hazards for people.
- People's individual risks relating to falls, choking, loss of weight and developing pressure ulcers were assessed and managed. One person told us, "Falls are my problem, but I am careful and I can call someone [staff] if I need them."
- Staff quickly identified changes in people's behaviour and mood. They took action to reduce people's distress or anxiety and to reduce potential risks which may arise from this. When needed people received one to one support to ensure their wellbeing and the safety of others.
- A record of incidents and accidents was kept. The action taken by staff in response to these was monitored to ensure it remained appropriate and effective in keeping people safe.
- Staff reflected on situations, incidents and accidents in order to continually learn from these in order to improve how they responded and to continue keeping people safe.

Staffing levels:

- Staffing numbers were reviewed and adjusted to ensure people's needs were met. Additional agency staff were used when people required one to one support.
- There were enough staff with the right skills and experience to look after people. One person said, "There are enough staff because they get agency staff if they are short." A relative told us, "There are always carers [care staff] in the lounge."
- Staff recruitment records showed that checks had been carried out on staff before they started work. This helped to protect people from those who may be unsuitable to care for them.
- New staff were supported to complete induction training and their suitability was monitored during a probationary period.

Safeguarding systems and processes /Learning lesson when things go wrong:

- Staff had been trained to recognise potential abuse and take appropriate action when they suspected this or when an allegation of abuse was reported.
- Managers took steps to share with relevant professionals and agencies, any safeguarding concerns they may have identified or which were reported to them.
- The provider's safeguarding policies and procedures were in line with the local multi-agency safeguarding procedures and protocols in order to safeguard people.
- The provider's policies and procedures supported and promoted good practice in supporting equality

and diversity and maintaining people's human rights. A visitor said, "I visit regularly, at different times of the day, and I have never heard or seen anything that has bothered me, in fact the opposite."

Using medicines safely:

•□We observed people receiving appropriate support to take their medicines safely. A relative said, "There are no problems with medication, they make sure my [relative] has swallowed it" and a person said, "I have no worries about medication, they [staff] ask if I have any pain; if I need some [pain relief] later I can go and ask for it."
•□Medicines were delivered to the home in time for people's use, which included end of life medicines. They were securely stored and returned to the pharmacy if not used.
•□Staff who administered medicines had received training and their competency was checked.
•□Medicine administration records showed that people had received their medicines as prescribed. These records, along with additional guidance for staff in relation to the use of people's medicines, were checked by managers to reduce risks of medicines errors.

Preventing and controlling infection:

- Cleaning schedules were followed by the housekeeping staff who kept the home sufficiently clean. A person said, "There is a nice woman who cleans my room, it is always nice." One member of the housekeeping staff told us how they cleaned one person's carpet in order to address potential infection risks.
- Staff wore protective aprons, gloves and tabards to prevent cross contamination when they delivered people's personal care and served people's food.
- The kitchen had been inspected by the Food Standards Agency and hygiene standards had been found to be "very good".
•□Laundry was managed in a safe way to reduce the potential spread of germs.
•□People and staff had been supported to have a flu vaccine. Further advice about this had been given to those who had declined this.

Good

Is the service effective?

Our findings

Care, treatment and support continued to achieve good outcomes for people, promoted a good quality of life and was based on best practice.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:

- People's immediate and ongoing needs were fully assessed, which included wound management, pain relief, bariatric care needs, nutrition and hydration and behaviour management needs.
- Treatment and care was planned and delivered in line with advice and best practice guidance from specialist health care professionals. Staff worked in collaboration with a range of external health and social care professionals to meet people's needs. These included for example, the NHS Rapid Response teams, to prevent unnecessary hospital admissions, speech and language therapists (SLTs) to manage swallowing and choking risks, specialist mental health practitioners to support positive behaviour management, tissue viability nurses when managing complex wounds and social workers to support people's social needs.
- Staff respected people's choices and their diverse preferences when planning their care.

Staff skills, knowledge and experience:

- The home's training record showed that all staffs training was in date and it gave a date for when an update was due. All staff received training in first aid, fire safety, food hygiene, infection control, health and safety, manual handling and safeguarding.
- Staff who delivered care also received training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), the Equality Act, end of life care, dignity and respect, dementia care, communication, person centred care and care planning.
- Training was also sought from the Care Home Support Team (CHST - a team of NHS health care professionals who support people and staff training in care homes) to ensure staff were up to date with best practice and new pathways of care. One registered manager told us they were waiting for training to be delivered by the CHST on Gloucestershire's NHS SKIN Bundle. This would then be incorporated into how staff assessed and planned care around pressure ulcer prevention and management. A relative said, "Staff definitely have had good training and have the right skills, they know how to look after my [relative] well."
- Nurses were supported to maintain their competencies and professional registration with the Nursing and Midwifery Council (NMC).
- Staff were provided with regular opportunities to discuss their training needs, performance and any concerns they may have. This was known as 'supervision'. Two staff members confirmed they had received supervision with the home manager and one said, "We can talk about anything."

Eating and drinking:

- The menu for the day was displayed and people could make a choice or were supported to choose their preferred meals. Two main options were cooked for lunch. People told us the cook would also provide an alternative if asked.

•□Comments about the meals were varied and included, "Lovely food, always a choice" and "The food varies a lot, it's like an industrial canteen food, there is a lot of repetition." We reviewed the four-week rolling menu which was also on display and this recorded a variety of meals across the four weeks.
•□People were provided with enough food to suit their individual appetite. A person said, "I get enough to eat, it is average." We observed someone ask for more fish and this was provided.
•□Hot drinks and biscuits were offered throughout the day and a supply of cold drinks were available in the lounge and bedrooms. We observed people's glasses being 'topped up' regularly.
•□People's nutritional and eating risks were identified and addressed. One person told us they were diabetic and, if they felt "peckish" during the night, staff tested their blood sugar before giving them something to eat.
•□Where people were at risk of not maintaining their weight, they were provided with food fortified with extra cream and butter so they received additional calories.
•□Staff were aware of people's choking risks and difficulties with swallowing and food was provided in suitable textures to meet their needs. Managers were aware of the new changes to the different definitions of altered textured foods under the International Dysphagia Diet Standardisation Initiative (IDDSI). They were awaiting further guidance from the CHST on the introduction of this.
•□Although at the time of the inspection, no-one required a special diet in accordance with their cultural or religious preferences, staff explained these would be and had been, accommodated.

Health care support:

•□Staff worked together and with other health and social care professionals to deliver effective care and treatment.
•□Arrangements were in place with a local GP surgery so that people received medical support and a review as needed. One person said, "If I am not well, they [staff] get the doctor to see me." Managers told us there was a good working relationship in place with a local GP who was supportive of the home.
•□People were supported to attend health appointments or their relatives escorted them. A person said, "I have had regular physiotherapy since I came here, but I now go to the gym at the hospital twice a week by ambulance."
•□Arrangements were made for people to access opticians, dentists and a chiropodist.

Ensuring consent to care and treatment in line with law and guidance:

•□The home obtained consent from people before providing care and treatment. A person said, "There are no restrictions here, I can please myself what I do."
•□In line with the Mental Capacity Act 2005 and where, appropriate, people's mental capacity had been assessed. Where people lacked mental capacity to make specific decisions, records showed these had been made in people's best interests. Records showed that staff consulted with appropriate representatives when doing this. Care was planned and delivered in the least restrictive way.
•□Staff had sought appropriate authorisation under DoLS when restrictions had been placed on people to ensure their safety.

Good

Is the service caring?

Our findings

The service continued to involve and treat people with compassion, kindness, dignity and respect.

Ensuring people are well treated and supported:

- Staff interacted with people in a kind, respectful and compassionate way. Staff were very patient, they spoke to people using appropriate volume and tone of voice.
- We heard terms of endearment being used appropriately with positive reactions.
- Feedback from people about how they were treated was positive. Comments included, "They love me here, they are all my friends and they help me" and "I get on brilliant with the staff, they are kind, patient and caring." A relative said, "I see the manager sitting talking to people, they are all caring and friendly here."
- Staff understood people's personal, cultural, social and religious needs. For example, a member of staff explained that staff had been able to have meaningful interactions with one person because they were from the same country and they understood much about what the person spoke about.
- People's independence was supported. One person told us how staff were supporting them to regain their independence to be able to return to their own home. Another person was more physically able and was supported to use the service independently and in a way which suited them.

Supporting people to express their views and be involved in making decisions about their care:

- Staff knew the people they cared for well as well as their likes and dislikes. This included people who could no longer express these. This was because staff had taken time to get to know people and explored these with people's representatives.
- People who could express their views and preferences had opportunities to do this and these were incorporated into how their care was planned and delivered. Comments from people included, "I am cared for in the way I wish and am happy with everything" and "I can do what I like here, nobody tells me what to do; I tell the carers [care staff] to choose what I wear, and I say when I am ready to go to bed".
- Relatives told us they had been consulted about all decisions made about their relatives' care. They had been able to add to this process by speaking on behalf of their relative. Relatives confirmed they were kept up to date with any changes in care.
- Care plans outlined and flagged up people's communication needs. Staff knew how best to communicate with people and how to make information accessible to them.

Respecting and promoting people's privacy, dignity and independence:

- People told us their privacy and dignity was maintained when staff delivered their care. A person said, "They [staff] are very respectful, they keep me covered up and allow me to do the bits I can myself."
- We observed staff knocking on people's doors and waiting for an answer before they entered; where it was possible to do this.
- People who received care in bed were provided with this in private; their bedroom door was shut and

other staff did not enter whilst this was taking place.
•□Care plans identified what gender of staff people preferred to deliver their personal care and their choice was respected.
•□Information about people's care and treatment was kept secure and confidential.

Good

Is the service responsive?

Our findings

People continued to receive personalised care that was responsive to their needs.

Personalised care:

•□People's care plans outlined how people's care was to be delivered in line with their preferences. Care was reviewed with people, or their relatives, where appropriate. A person said, "I know my care plan, everything I want, I have asked for."
•□Improvements were being made to the care plans and overall care files. For example, care plans were being further personalised and typed, rather than hand-written, and sections added to the file to make finding information easier.
•□Staff attended comprehensive daily handover meetings which updated them on people's care needs and any changes to this.
•□People were supported to take part in group or one to one activities. For example, we observed a person receive a hand massage in the morning and in the afternoon, more people were supported to join in a game with a balloon. Others enjoyed completing puzzles and playing cards.
•□Feedback from people and relatives included, "My [relative] complains there are not many people to talk to, or enough to do", "Staff encourage people to join in and do things; the programme depends on what else is going on", "There's not enough to do, I just sit in my chair and watch the comings and goings" and "I lack conversation, staff come in when they can and keep me amused."
•□We considered the above feedback when gathering evidence around the activity provision. We did observe staff sitting with people on several occasions, chatting and laughing with them. There were photographs of people having taken part in various activities, on other days, on display and there was activity equipment present in the lounge-dining area.
•□Although the home did not employ a specific activities coordinator, activities and meaningful interactions were supported by the staff. External entertainers regularly visited the home to provide entertainment and lead on fitness sessions.

We recommend that the service finds out more about whether the activities provided to people are meaningful to them and where needed, make adjustments to support people's social needs.

•□Improvements had been made to the garden which had provided people with a safe outside space to enjoy in the warmer months. The changes also provided better view from the dining area.

Improving care quality in response to complaints or concerns:

•□People told us they were not aware of the home's formal complaints procedures, but they confirmed they were not afraid to complain if they needed to. They felt able to speak with the home manager about anything.
•□The provider's complaints policy and procedures were displayed and outlined how complaints would be responded to. Managers confirmed that they could provide this information in other formats if needed.

•□Two people told us they had raised minor concerns and these had been resolved to their satisfaction. We spoke with a member of staff about one of these concerns and how they had successfully resolved this for the person.
•□A record was kept of all complaints which recorded how each complaint had been managed. Records included a response, the actions taken, investigation notes where appropriate, and the outcome. People's complaints were responded to according to the provider's policy and procedures.

End of life care and support:

•□Staff supported people at the end of life to have a comfortable and dignified death.
•□We visited one person who was nearing the end of their life. They looked comfortable, records and staff confirmed they were having their care needs attended to and staff were observed to be gentle and compassionate towards them
•□There were well established links with GPs, pharmacies and community nurses to support people's end of life needs. The home had purchased its own specialised piece of equipment which, when required, could be used to administer end of life medicines. This avoided any dependency on the community nursing teams to have to lend this to the home and meant it was available at all times if required.
•□End of life care plans recorded people's end of life care wishes as well as their pastoral and religious preferences.
•□Relatives and other people who mattered to the people, were supported at this time.

Good

Is the service well-led?

Our findings

The management of the home continued to support good outcomes for people and make on-going improvements to the overall service.

Leadership and management:

- There were two managers registered with the Care Quality Commission (CQC). Both these registered managers were actively involved in the management of the home.
- A 'home manager' was also employed to oversee the day to day management of the home. They communicated daily with the registered managers. Managers collectively held responsibility for the smooth running of the service.
- All the managers had appropriate experience, training and qualifications to be able to provide leadership and support people's needs and wellbeing.
- It was apparent through our observations and from what people said, that the home manager was well known and well liked. We observed them several times sitting and chatting with people in a friendly way with good humoured banter which was enjoyed by the people they were chatting with. One person said, "The manager [home manager] is a gentleman and a man of honour, he always does his best for everyone."
- There was respect shown to the registered managers by the staff and vice versa.

Plan to promote person-centred, high-quality care and good outcomes for people:

- All managers supported and promoted person centred care and arrangements were in place to monitor its provision, along with the quality of the care provided.
- Where expected standards of care and professionalism had not been met, the registered managers had taken appropriate action, in accordance with their policies, procedures and HR advice, to address this.
- All managers made their expectations clear to the staff through formal and informal meetings and through discussion during each day.
- Several staff had worked for the provider for many years and the overall staff team were committed to the managers' values and expectations.

Managers and staff were clear about their roles, and understand quality performance, risks and regulatory requirements; continuous learning and improving care:

- Managers understood their responsibilities and ensured staff were supported to understand theirs. All staff received an annual appraisal which reviewed their performance to date and explored areas for improvement and development.
- All staff were aware of their individual responsibilities when it came to the management of risks and meeting with regulatory requirements.
- Some staff had additional roles to support the implementation of current good practice across the home. Two staff were dignity champions. It was their responsibility to support other staff in maintaining dignity in

care. One registered manager had completed a leadership course in dementia care and was looking at ways of improving outcomes for people who lived with dementia.

- Registered managers were fully aware of the risks and challenges which faced the service and addressed these on behalf of the provider.
- Audits were completed on a regular basis to monitor service arrangements and staff practice. Areas covered by these included for example, infection control, food hygiene, health and safety, fire safety, medicines management and care planning.
- Whilst audits were completed; the actions to address shortfalls and manage risks till the actions were completed were not always consistently recorded. This would also apply to suggestions and ideas adopted and planned for to show how feedback had been used to improve the service
- We discussed with the registered managers the benefits of adopting and maintaining a continuous service improvement plan. This could record and give an audit trail of all necessary actions for improvement and provide information about those already completed and planned for. For example, in relation to replacing the carpet and managing trip hazards till this work was completed.

We recommended that the service seek advice and guidance from a suitable source, in relation to the recording of actions identified, planned and completed when making improvements to the service.

Engaging and involving people using the service, the public and staff:

- People and relatives felt they had opportunities to speak with managers and provide feedback or make suggestions.
- Staff had opportunities to make suggestions and put forward ideas which would benefit the home. Regular meetings with staff were held to ensure they were kept up to date with any changes or plans for the service.

Working in partnership with others:

- The registered managers had well established links with other care home providers, local hospitals and a good working relationship with local commissioners of care. These relationships supported quick and effective access to the home for people discharged from hospital, but who required further assessment and for those where other services could not accommodate their needs.
- Links with relevant professionals ensured for example, that staff received training in line with Gloucestershire's Dementia Training Pathway and there was a link to the Gloucester Meaningful Activity and Wellbeing network all of which helped to support better outcomes for people.
- Links with local schools promoted and supported integration between older and younger people.