Windmill Healthcare Limited

Windmill Lodge Care Centre

Inspection Report

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Overall summary

Windmill Lodge Care Centre provides nursing and personal care to 93 older people, 87 of whom were present when we visited. There are four floors in total. The ground floor offers residential care, and the other three floors provide nursing care. All areas of the home are wheelchair accessible. The home has a registered manager; the same person has been in post since the home opened ten years ago.

We spoke with forty people living in the home. The people using the service told us they felt safe and relatives we spoke with were confident that their loved ones were safe and comfortable in this home. An external healthcare professional involved in the service told us they had no concerns about the welfare of people living in the home and had confidence in the ability of staff there to look after people in their care and keep them safe.

There were policies and procedures in place for minimising and managing risk and these were effective. Staff understood the importance of risk assessments and followed guidance to protect people. Restrictions were minimised so that people felt safe but also had the most freedom possible regardless of their needs.

The home ensured people had enough suitably skilled and qualified staff available to meet their needs. Staff received training and development to make sure they were equipped for their role. People in the home were shown compassion and kindness.

Care, treatment and support plans were kept under review and reflected people's needs, choices and preferences. Staff were aware of changes to people's care and support needs and were responsive to them. People received care and support from staff that knew their history, and responded to their likes, preferences, needs, hopes and goals. Staff understood equality and diversity; this was reflected well in practice; staff responded appropriately to each person's diverse cultural and spiritual needs and met their care and support needs promptly. Appropriate referrals were made to other health and social care services as necessary. Specialist or adaptive equipment was made available as and when needed. The service made good provision for caring for and treating people approaching the end of their lives.

The service offered people opportunities to participate in activities within the service or in the community. Staff made sure that people were able to keep relationships that mattered to them such as family, community and other social links, those without relatives were offered advocacy or a volunteer befriending service

The staff team demonstrated shared values, such as compassion, dignity, equality and respect and put them into practice. Staff were effectively supervised and supported; the feedback to staff was constructive and motivating. The management team worked alongside organisations such as the Gold Standard Framework to promote and guide best practice in caring for people approaching the end of their life.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

People were treated with respect and dignity by the staff. Safeguarding procedures were robust and staff understood how to safeguard the people they supported. Systems were in place to make sure that managers and staff learnt from events such as accidents and incidents, complaints, concerns, whistleblowing and investigations.

The home was clean and tidy and infection prevention and control measures were observed to protect the people who lived there.

Staffing levels were appropriate with suitably qualified and skilled staff to meet the needs of people at the end of life. Staffing levels enabled staff to have time to develop positive and meaningful relationships with people in their care, as a result they were more likely to recognise the signs if individual people were suffering or felt unsafe.

Windmill Lodge undertook assessments for all people admitted, these included capacity assessments which were reviewed at regular intervals. All staff had a good working knowledge of the Mental Capacity Act 2005. In our disussions we found staff were able to describe examples of scenarios when a person may need to be be deprived of their liberty to keep them safe. Staff appeared confident in following the referral process for a Deprivation of Liberty Safeguards (DoLS). None of these had been necessary but we saw examples of when staff requested "best interests" meetings, these involved social worker and family members where relevant.

Are services effective?

People's needs were met because staff were aware of the content of people's care plans and provided care, treatment and support in line with them. Staff demonstrated a high level of understanding and respected people's individual needs, choices and preferences.

The home had consistent arrangements in place to ensure that the needs of people were assessed prior to admission by staff who had the skills required to do so. Care plans were up-to-date and reflected people's needs, choices and preferences. Appropriate referrals to other services were made as soon as a need was identified, so that people's needs could continue to be met.

Summary of findings

Staff had the right competencies, knowledge, qualifications, skills, experience, attitudes and behaviours to enable them to provide support and meet people's needs effectively. The service had systems in place to ensure that any gaps in these areas were addressed in a timely manner.

Are services caring?

People in the home were shown compassion and kindness. Staff communicated effectively with people using the service, no matter how complex their needs. Staff developed trusting relationships and respected confidentiality.

People received their care and support from staff who knew and understood their history, likes, preferences, needs, hopes and goals. Staff responded to each person's diverse cultural and spiritual needs. People contributed to their own care plans so that staff knew their wishes particularly in relation to end of life care. This was discussed with the person and with appropriate health professionals

The physical environment supported people's privacy, confidentiality and promoted their independence

Are services responsive to people's needs?

Management and staff responded appropriately if people's needs changed. Staff recognised and responded to people's social and cultural diversity, values and beliefs that may influence their decisions and how they wanted to receive care, treatment and support.

People who used the service were encouraged and supported to engage with services and events inside and outside of the home. Input from other services and support networks was encouraged.

The service had staff that had an enabling attitude towards informed risk taking and confidentiality.

People tell us that staff understood their needs, knew how to meet them and were proactive in suggesting additional ideas that the person might not have considered.

Staff had worked closely with palliative care specialists and engaged in their training to learn how to deliver the care to a high standard. People were given support when making decisions in regards to their preferences for end of life care. There were systems in place to ensure that staff were available to support people using the service as well as people who were important to them in the last days of life.

Summary of findings

Are services well-led?

The service had a clear vision which was put into practice; values such as compassion, dignity and respect were on display. The home promoted a culture of learning from mistakes and had an open approach. If people raised concerns they were listened to and thorough investigations took place.

Management arrangements provided strong leadership, there was a positive and empowering culture. Leadership was visible and effective at all levels, and staff had clear lines of accountability for their role and responsibilities. The management team worked well alongside partner organisations.

Support and supervision of staff was consistent. There was evidence that the dependency levels and needs of people who use the service were used to determine staffing levels. The management team had a good understanding of equality and diversity issues and put these into practice.

Summary of findings

What people who use the service and those that matter to them say

We spoke with more than forty people using the service, this included people living on each of the four floors. Overall, people praised the nursing home and the care and the support provided. A person told us they were familiar with area and lived locally, they said, "I recommend this home and feel fortunate to have come here when I could not live alone any longer, I feel I belong to this community now".

People told us they felt safe using the service. One person smiled and told us, "the staff look after me too well, I love it here and feel secure, it is good to know we have a good care home in this area as my friends live local. Everybody working here has a good heart, they are all very respectful."

Another person told us how the change from their home environment had affected them but their move to the home was made smooth, they said, "it's nice here I would prefer to be in my own home of course, but it's okay here and the staff are nice to me."

Everyone we spoke with said they got the type of care they needed, they were able to access community healthcare professionals when required. Comments we received included, "On the whole the staff are very kind and caring; I feel happy here. I enjoy the garden and the staff are very kind to me."

People told us they received staff support to attend health appointments if relatives were not available. They also told of weekly visits from a local GP. A person said, "we are well looked after, and see the doctor or dentist if we need to, what more could you want?"

The majority of comments we received reported on the consistent leadership experienced and the benefits of having a reliable manager who people felt had a visible presence.

We spoke with a person who had visited the service each week for the past ten years to spend time with those who had no relatives. They told us, "the staff are generally great and people are well cared for. The manager always knows what's going on and the home is well managed."

A visitor's comments to us included, "it's lovely here; my relative says it is like being in a good hotel. We have no concerns at all, the care is good and the staff are nice."

Another visitor told us, "My [relative] goes to Windmill for respite care a few times each year. We see that they are well cared for, and have never had any concerns about the care they receive."

A third visitor said the service made sure it reflected the cultural and religious needs of the people living in the home. They said, "they pay attention to Black History month and have events and activities to celebrate black history. They help many of the people to continue to enjoy their favourite things

Windmill Lodge Care Centre

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 of the Health and Social Care Act 2008. It was also part of the first testing phase of the new inspection process CQC is introducing for adult social care services.

The inspection team included the lead inspector and an inspector colleague, a specialist advisor in end of life care, and an expert by experience in caring for older people.

This service was last inspected in September 2013, and it was found to meet all regulations.

On the day we visited, there were 87 people living in the home, and we spoke with over forty people, we spent time speaking with people on each floor and observing their care. We spoke with nine people who were visiting and they told us of their experiences. We spoke with the registered manager, the clinical manager, four nurses, seven carers, and two ancillary staff and the hairdresser.

We looked at all areas of the building, including people's bedrooms (with their permission), the kitchen, bathrooms and communal areas. We also spent time looking at records, which included the electronic and paper files for eight people using the service, and also the records relating to the management of the home.

Before our inspection, we reviewed all the information we held about the home and contacted three health and social care professionals involved in the care of people that lived there. The local authority held provider monitoring meetings every three months, they shared with us information in contract monitoring reports. We asked the provider to complete an information return and we used this information after the inspection to help us complete our findings.

Are services safe?

Our findings

The people using the service told us they felt safe and relatives we spoke with were confident that their loved ones were safe in this home. We received positive reports about the safety of the service from the local authority contract monitoring department, they visited the home frequently to monitor the service and held quarterly meetings with the provider. An external healthcare professional involved in providing a service to people in the home told us they had no concerns and were confident in the ability of the service to keep people safe.

The service ensured they had systems in place to promote the healthcare needs of people and

reduce risks. People at risk of developing pressure sores were identified, and those confined to bed were nursed in electrically adjustable beds with pressure relieving mattresses. We saw that, where necessary, the beds had padded cot sides in situ to prevent people from injuring themselves.

People received their medicines as prescribed, and we saw that they were frequently asked if they were in any pain. We saw that controlled drugs were stored safely in line with current regulations and guidance. Medicine audits were undertaken weekly; these weekly checks ensured all medicines were administered correctly and stored safely in the home.

The staff we spoke with all knew what action to take if they witnessed or suspected any form of abuse. Staff told us they had received training about safeguarding adults and were invited to refresher training when required. A member of staff said, "our training makes sure we know how to keep vulnerable people safe, and to report unacceptable practice."

The provider had employed someone to review their policies and procedures to ensure they protected people's human rights. All staff had a good working knowledge of the Mental Capacity Act 2005 and Mental Health Act 1983. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards. While no applications had been submitted, proper policies and procedures were in place but none had been necessary. Relevant staff were trained to understand when an application should be made, and in how to submit one.

Staff described occasions when "best interest" meetings were held for people to protect their rights, and the parties involved included health and social care professionals. This helped ensure decisions were made in the person's best interests.

People were safe because there were enough staff available to meet their needs. People living on each floor told us staffing levels were "good" and there were sufficient numbers of staff on duty to meet their needs. We saw from records and heard from staff that the needs of people using the service were kept under review, and staffing levels were arranged accordingly. For example, we saw evidence that an additional member of staff was assigned to the team if a person required one to one support in the home or to attend an external appointment.

Staff told us that they had enough time to meet the needs of all of the people they were caring for. Staff demonstrated an understanding that someone's behaviour may become challenging if their needs were not being met. For example, a staff member explained that one person's well-being had improved significantly since they started engaging in activities they enjoyed. We saw that communal areas had a member of staff present to assist at all times and that staff had time to spend caring for and talking with people. People told us that staff came to them quickly when they needed help. Relatives told us there were always staff around for them to talk to.

Staff had maintained a record of people's personal possessions, each person had a lockable cabinet to store valuables, and the service also offered this facility in the office. This helped to protect people from financial abuse.

The home was clean, tidy and comfortable, and staff observed infection prevention and control measures to protect everyone living, working or visiting the home.

The service had sourced training on falls prevention from a doctor. The provider told us they had seen a reduction in the number of falls in the home. One person told us, 'staff are always present; they look after you so you don't fall. When I am in a wheelchair they are very keen that I don't fall." Systems were in place to ensure that the equipment in use was checked and any faults reported swiftly so that repairs could be done. Staff were reminded about this during team meetings.

Are services effective?

(for example, treatment is effective)

Our findings

We used using pathway tracking to look at care records for people on each floor. We observed the care and support given and talked with people using the service and with staff. The service showed us that people's needs were being effectively met.

We saw people had the support and equipment they needed to enable them to be as independent as possible. For example, mobility aids were at hand for those who required them and if people needed staff support to eat their meals this was provided. These measures ensured people could remain as independent as possible. People spoke of being consulted about their care planning and reviews and of staff taking appropriate follow up action to respond to their changing needs.

One family used the service for respite care for their relative. They said that this was a good service and gave the family a break. They had no concerns about the care provided.

One person had a list of exercises with visual prompts on their bedside table following consultation with an occupational therapist. They told us that staff helped them to exercise. The same person told us they had regular health checks. They also said, "as soon as you complain about an ailment, they take charge of it, they call in the doctor."

We looked at care plans for people on all four floors and saw they reflected people's current needs, choices and preferences. People's assessments had been reviewed and amended when people had a change in their needs and referrals were made to healthcare services when appropriate. This ensured that people were seen by relevant health professionals. This showed the service effectively supported and promoted individuals' health and welfare.

There were opportunities for people to express their views about their health and quality of life; these were taken into account in the assessment of their needs and the planning of the service. One person had specific communication needs. Staff explained that they had worked with the family to put a set of pictures in place to enable the person to indicate their needs to staff and to help staff to offer choices more effectively. Staff reported that the system had increased communication and was working well.

The service cared for many people who were approaching the end of their lives. We saw how people on the nursing floors had Advance Care Plans in place. Where there was a Do Not Attempt Resuscitation (DNAR) order in place this was signed by a GP. The GPs attended bi-monthly meetings at Windmill Lodge Care Centre to discuss people in the last year of life. We saw that each floor had a folder with a list of every person, their care needs, and whether or not they had a DNAR order in place. We saw evidence that information was also shared at the bi-monthly Gold Standard Framework meetings with all appropriate organisations such as the Ambulance Service, GP practice and GP out of hours service. This helped to ensure that the wishes of the person would be followed.

People had a named doctor and the registered manager had allocated a key nurse and health care assistant to ensure that people's needs were managed by staff who knew them. We saw that there had been thoughtful consideration given to matching people with staff who understood their needs and culture.

The service had access to specialist services; there were reviews on people's care files showing input from the cardiac nurse, diabetic nurse, tissue viability nurse team, speech and language therapist, physiotherapist and occupational therapist. We saw evidence which confirmed how staff supported two people who were recently hospitalised. Staff had worked well with hospital staff and community healthcare professionals to make sure people received the support they needed when they returned back home. This meant staff ensured people got the care they needed following discharge.

We found the building was well designed for meeting the needs of people who lived there. All the bedrooms were spacious, light and airy. Each room had an en-suite shower room and toilet, plus a fitted wardrobe. Some of the people we spoke with also had their own pieces of furniture in their rooms.

All the corridors were wide with handrails to support and encourage mobility. People had access to appropriate space to see their visitors, for activities and to spend time together or be alone. There were two trained activities coordinators. They provided one-to-one activities support for people who preferred to stay in their bedrooms and coordinated activities for staff to provide in the communal lounges.

Are services effective?

(for example, treatment is effective)

One activities coordinator told us they encouraged health care assistants to provide hand massage and foot spas, and we observed these pampering sessions in progress. Staff were skilled in providing hair and skin care for people from many cultural backgrounds.

We saw systems of staff supervision were in place, staff competence was tested after relevant training courses.

Are services caring?

Our findings

Everyone we spoke with agreed staff respected people's privacy and dignity. A person said, "They close the door when they need to."

A person told us they had adjusted well to their new home, they said, "I'm happy here, well looked after, no complaints. I've been here a year, I couldn't be in a better place. They're very good."

Another person said, "Since I've been here I've been very happy."

People told us they were treated with kindness. We saw that staff responded to people warmly. We saw positive interactions from all members of the staff team. This included the manager, nurses, health care assistants, domestic staff and maintenance staff. We saw that all staff took time to talk to people. On each occasion the person's first name was used and accepted and the conversations were friendly. One person who used Windmill Lodge for respite care said, "'I come here out of choice. I always have the same room, I am familiar with the staff, know their names."

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People who wished to were enabled to maintain relationships with their friends and relatives. We saw that people met with their visitors in the privacy of their bedrooms and some met their friends in the communal areas. There were additional meeting rooms available if required.

The service recognised the risks of social isolation and loneliness and had systems in place to minimise this. For example the registered manager worked closely with a volunteer visitor to make sure they visited those who had no other visitors. One person who received this service told us they looked forward to the visit. The home regularly arranged a registered pet therapy session which people told us they enjoyed. Staff told us the people who were in their last year of life particularly enjoyed this service.

The management team had an ongoing workforce development plan that encouraged staff to develop and promoted innovative practice. People's care and treatment reflected relevant research and guidance, for example the service had worked with a local hospice and introduced the Namaste programme. (Namaste Care is a programme to engage people through the pleasant stimulation of the five senses: taste, touch, smell, sight and hearing). A health professional told us the improvements were tangible in care planning arrangements since this programme was introduced in the home, and that it contributed to improved outcomes for people. The service had achieved Beacon Status for end of life care through the Gold Standard Framework (GSF). Staff told us they had taken on board recommendations made by external professionals that involved the doctor in the consultation process for people receiving end of life care.

A service development manager regularly met with the people using their service and their relatives and visitors to gain their views. Their input was also sought by surveys, and post-admission questionnaires had been introduced for people to feedback how well their move to the home had gone. The service development manager told us that this reinforced the message that the people using the service were in control.

Records and feedback demonstrated that staff had completed a Skills for Care induction, and almost all of the staff had completed their mandatory core training. A large number of care staff had completed National Vocational Qualifications. This meant that staff had the skills and knowledge they needed in their roles.

Staff told us they had the time they needed to provide the care and support to meet people's needs. People received care and support in accordance with their preferences, interests, aspirations and diverse needs. The staff we spoke with gave examples of how people's interests and diverse needs had been taken into consideration in planning their care and support. For example people who approached the end of their life were supported with culturally appropriate skin and hair care.

People could continue their spiritual lives whilst living at the service. Halal meat was available for Muslim people and non-halal meat was available for others. The provider had arranged for clergy from various denominations to visit the home to help people who wished to continue their religious observances.

Staff actively monitored the welfare of people, we saw in records they recognised if someone was uncomfortable or in pain and they took prompt action to ensure they were made comfortable. We saw that people at the end of life were prescribed anticipatory medicines for pain and nausea. Staff told us they felt very sad when anyone died, particularly when they had looked after them for a long time. Staff were invited to attend a de-brief meeting following a death where they could discuss the person, and how the death has made them feel. One nurse said she always felt that she could talk to her colleagues if she felt upset or just wanted to talk about how she felt.

People felt confident to express any concerns or complaints about the service they received. People told us that if they had any concerns they raised them with staff and were listened to.

Systems were in place to enable the provider to monitor how concerns and complaints were investigated and resolved.

We saw that some people preferred to stay in their bedrooms. In these instances we saw that staff ensured that they had access to emergency call bells should they need assistance. One person who preferred to stay in their bedroom confirmed, "staff come quickly if I call them and

Are services responsive to people's needs?

(for example, to feedback?)

they stay with me if I am feeling poorly." We saw staff providing sensitive reassurance to a person who became anxious and upset: they talked to them to them and gently stroked their head until they settled.

We noted that staff visited people whilst they were in hospital in preparation for their return to the home. This meant they could assess people's needs and revise their care plans and risk assessments as necessary. One person had been discharged back to the home with physiotherapy exercises to do to regain their mobility. Physiotherapy plans had been added to their care plan. They had been put on a soft diet whilst in hospital and they were not happy about this. We saw that staff had listened and had requested the speech and language therapist reassess the need for a soft diet as soon as possible.

One person had returned from a hospital stay with increased needs. Staff provided nutritional supplements and monitored their food and fluid intake, weighing them each week to make sure their nutritional needs were being met. A profiling bed was in place with a pressure relieving mattress. The registered manager was arranging for a reassessment of the person's needs, but had made extra support available in the meantime.

From tracking care plans and looking at records of care provided by health professionals we saw that staff responded quickly to people's changing needs and symptoms. For example, staff noticed that one person had a sore eye. Records showed they were seen by their GP to get the eye checked on the same day. Records also showed us that if somebody had a fall they were checked by their GP or by paramedics. Possible causes for the fall were investigated quickly. This meant that staff acted promptly and appropriately to seek medical intervention when there were concerns.

Are services well-led?

Our findings

The service was well- led. The manager was registered with the Care Quality Commission and had been in post for many years. The provider visited the service at frequent intervals to monitor and oversee the operation of the service. We saw they reported on their findings, and followed up on any quality issues identified. We received confirmation from external bodies that the service worked well in partnership with others to make sure people received their care in a joined up way.

The management team worked well alongside organisations that promoted and guided best practice. They had participated in a falls prevention training programme, and an analysis was then carried out which showed a reduction in injuries sustained from falls in recent months.

Management arrangements provided strong and consistent leadership with a clear focus and an empowering culture. Leadership was visible and effective at all levels and staff had clear lines of accountability for their role and responsibilities. People using the service, their relatives and

The provider promoted a positive and respectful culture. Staff told us that they felt comfortable raising any concerns or service improvement issues and they felt they were listened to. Concerns and complaints had been used as an opportunity for learning and improvement and were well monitored by the provider and senior management. We were informed of actions taken to eradicate poor practice, for example, the use of disciplinary procedures.

Staff felt motivated, people found they were caring, well-trained and supported. Staff told us the registered manager promoted best practice, encouraged people to attend training, and always had an open door policy. Staff told us they felt supported to carry out their role and there was always someone to ask if they were unsure of anything.

There were procedures in place for whistle-blowers to raise concerns. There were regular staff meetings where the results of health and safety audits were discussed with staff to ensure they understood any action that was required. During these meetings the registered manager told us that scenarios relating to mental capacity and deprivation of liberty were discussed with staff to ensure they understood what had to be done.

The service had a workforce development plan. The registered manager monitored training needs, identified any gaps in provision and made arrangements to fill the gaps. Care planning training was delivered to staff in the past year and, amongst other topics, it covered some of the administrative aspects of end of life care. People's dependency levels were regularly assessed and we saw that the information was taken into account when deploying staff members.

Staff champions had been appointed in infection control, equalities and diversity, continence care, nutrition, end of life care and dignity. These staff champions had received additional training that enabled them cascade their knowledge and practice to colleagues.