Care Quality Commission

Deepdene Care Limited

Woodtown 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

Summary of findings

Overall summary

This unannounced inspection took place on 27 May 2016. We returned on 1 and 2 June 2016 as arranged with the manager to complete the inspection.

Woodtown House is registered to provide 24 hour nursing care to 28 people with a past or present mental illness. At the time of our inspection there were 23 people living at Woodtown House.

There was no 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 manager had started the process of registering, but due to personal circumstances was now not going to proceed with registration. The previous registered manager still worked for the organisation as a clinical director and continued to support the home. We were assured that measures were in place to manage the service whilst they recruited. These measures included, the deputy manager stepping into the role, supported by both the clinical lead and clinical director.

The organisation recognised the importance of staff receiving regular support to carry out their roles safely. However, due to management changes between spring and autumn of 2015, staff had not been receiving formal supervision to identify any specific needs. Staff did confirm they felt supported at this time due to the strong team working which took place. The manager had recognised this deficit and a supervision schedule had been developed. The schedule confirmed that the majority of staff had received supervision in May 2016.

There were effective staff recruitment and selection processes in place. Staffing arrangements were flexible in order to meet people's individual needs. Staff received a range of training to keep their skills up to date in order to support people appropriately. Staff spoke positively about communication and how the manager worked well with them, encouraged team working and an open culture.

People felt safe and staff demonstrated a good understanding of what constituted abuse and how to report if concerns were raised. Measures to manage risk were as least restrictive as possible to protect people's freedom. People's rights were protected because the service followed the appropriate legal processes. Medicines were safely managed on people's behalf.

Care files were personalised to reflect people's personal preferences. Their views and suggestions were taken into account to improve the service. They were supported to maintain a balanced diet, which they enjoyed. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them.

Staff relationships with people were caring and supportive. Staff were motivated and inspired to offer care

that was kind and compassionate. People engaged in a variety of activities and spent time in the local community going to specific places of interest.

A number of effective methods were used to assess the quality and safety of the service people received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People said they felt safe and staff were able to demonstrate a good understanding of what constituted abuse and how to report if concerns were raised. People's risks were managed well to ensure their safety.

Staffing arrangements were flexible in order to meet people's individual needs.

There were effective recruitment and selection processes in place to protect people.

Medicines were safely managed.

Is the service effective?

Good

The service was effective.

Staff had not been receiving formal supervision to identify any specific needs between spring and autumn 2015. However, staff did confirm they felt supported at this time due to the strong team working which took place. The manager had recognised this deficit and a supervision schedule had been developed and the majority of staff had now received supervision.

Staff received a range of training which enabled them to feel confident in meeting people's needs and recognising changes in people's health.

People's health needs were managed well through contact with community health and social care professionals.

People's rights were protected because the service followed the appropriate guidance.

People were supported to maintain a balanced diet, which they enjoyed.

Is the service caring?

Good

The service was caring.

People said staff were caring and kind.

Staff relationships with people were caring and supportive. Staff spoke confidently about people's specific needs and how they liked to be supported.

People were able to express their views and be actively involved in making decisions about their care, treatment and support.

Is the service responsive?

Good

The service was responsive.

Care files were personalised to reflect people's personal preferences, which were met with staff support.

People engaged in a variety of activities and spent time in the local community going to specific places of interest.

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments.

Is the service well-led?

Good

The service was well-led.

There was no registered manager in post. The manager had started the process of registering, but due to personal circumstances was now not going to proceed with registration. The previous registered manager still worked for the organisation as a clinical director and continued to support the home. We were assured that measures were in place to manage the service whilst they recruited. These measures included, the deputy manager stepping into the role, supported by both the clinical lead and clinical director.

Staff spoke positively about communication and how the manager worked well with them.

People's views and suggestions were taken into account to improve the service.
The organisation's visions and values centred around the people they supported.

A number of effective methods were used to assess the quality and safety of the service people received.

Care Quality Commission

Woodtown 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.

This unannounced inspection took place on 27 May 2016. We returned on 1 and 2 June 2016 as arranged with the manager to complete the inspection.

The inspection team consisted of two adult social care inspectors.

Prior to the inspection we reviewed the Provider Information Record (PIR) and previous inspection reports. The PIR 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 and notifications we had received. A notification is information about important events which the service is required to send us by law.

We spoke with 14 people receiving a service and 11 members of staff, which included the manager.

We reviewed five people's care files, three staff files, staff training records and a selection of policies, procedures and records relating to the management of the service. After our visit we sought feedback from health and social care professionals to obtain their views of the service provided to people. We received feedback from two professionals.

Good

Is the service safe?

Our findings

People felt safe and supported by staff. Comments included: "I would talk to staff if I was concerned about something" and "The staff keep us safe."

Staff demonstrated an understanding of what might constitute abuse and knew how to report any concerns they might have. For example, staff knew how to report concerns within the organisation and externally such as the local authority, police and to the Care Quality Commission. Staff records confirmed staff had received safeguarding training to ensure they had up to date information about the protection of vulnerable people. We found that a new member of staff had not yet completed any formal safeguarding training. However, they demonstrated a comprehensive understanding of what constituted abuse. They knew their responsibilities and how to report concerns and had discussed safeguarding with the manager as part of their induction. By the third day of our inspection, they had completed formal safeguarding training, which showed the service was responsive when issues were identified.

The manager demonstrated an understanding of their safeguarding roles and responsibilities. They explained the importance of working closely with commissioners, the local authority and relevant health and social care professionals on an on-going basis. There were clear policies for staff to follow. Staff confirmed they knew about the provider's safeguarding adults' policy and procedure and where to locate it if needed.

People's individual risks were identified and risk assessment reviews were carried out to keep people safe. For example, risk assessments for behaviour management, falls and accessing the local community. Risk management considered people's physical and mental health needs and showed that measures to manage risk were as least restrictive as possible. For example, people had guidelines in place for staff to follow if a person was feeling distressed. These guidelines had been developed with support from key health and social care professionals to ensure staff were adopting best practice.

Staff confirmed that people's needs were met promptly and felt there were sufficient staffing numbers. During our visit the needs of people needing support were met promptly. For example, staff spent time with people engaging in a range of activities both within the home and local community.

The manager explained that there was one nurse and three support workers on duty throughout the day. In addition, there were members of the management team, administrator, activities worker, domestic and maintenance staff throughout the day who supported the care staff. Staffing arrangements were also flexible when there were changes in people's physical or mental health. For example, staffing levels increased when a person's mental health had deteriorated in order to keep both them and others safe. At night there was one nurse and two support workers on duty. Unforeseen shortfalls in staffing arrangements, due to sickness, were managed through regular staff and consistent agency staff so people's needs could be met by staff members that understood them. In addition, the service had on-call arrangements for staff to contact if concerns were evident during their shift. The on-call arrangements were shared between members of the management team.

There were effective recruitment and selection processes in place. Staff had completed application forms and interviews had been undertaken. In addition, pre-employment checks were done, which included references from previous employers and Disclosure and Barring Service (DBS) checks completed. Qualified nurses had their professional registration checked with the Nursing and Midwifery Council. This demonstrated that appropriate checks were undertaken before staff began work in line with the organisations policies and procedures. This was to help ensure staff were safe to work with vulnerable people.

People's medicines were managed so they received them safely.   Appropriate arrangements were in place when obtaining medicine. The home received people's medicines from a local pharmacy on a monthly basis. When the home received the medicines from the pharmacy they had been checked in by a registered nurse and one support worker and the amount of stock documented to ensure accuracy.

Medicines were kept safely in a locked medicine's room. The room was kept tidy and in an orderly way to reduce the possibility of mistakes happening. Medicines were safely administered. People were asked if they needed any medicines which were prescribed 'as needed' (known as PRN), such as pain relief. Medicines recording records were appropriately signed by staff when administering a person's medicines. A weekly audit was undertaken to ensure people were receiving their medicines as prescribed. The checks also ensured medicines remained in date. The manager then signed off the audit as one part of their responsibilities, which then formed part of their weekly and monthly reports to head office.

The premises were adequately maintained through a maintenance programme. Fire safety checks were completed on a daily, weekly, monthly and annual basis by staff employed by the service and external contractors. For example, fire alarm, fire extinguishers and electrical equipment checks. Staff had received health and safety and fire safety training to ensure they knew their roles and responsibilities when protecting people in their care. People were protected because the organisation took safety seriously and had appropriate procedures in place.

Good

Is the service effective?

Our findings

The organisation recognised the importance of staff receiving regular support to carry out their roles safely. However, due to management changes between spring and autumn of 2015, staff had not been receiving formal supervision to identify any specific needs. Staff did confirm they felt supported at this time due to the strong team working which took place. The manager had recognised this deficit and a supervision schedule had been developed. The schedule confirmed that the majority of staff had received supervision in May 2016. Staff had received an annual appraisal in order for them to feel supported in their roles and to identify any future professional development opportunities. Appraisals were structured and covered a review of the year, overall performance rating, a personal development plan and comments from both the appraiser and appraisee. Staff files and staff confirmed that appraisals had taken place.

Staff had completed an induction when they started work at the service, which included training. The induction required new members of staff to be supervised by more experienced staff to ensure they were safe and competent to carry out their roles before working alone. The induction enabled the organisation to assess staff competency and suitability to work for the service. New staff were also completing the new care certificate. The care certificate aims to equip health and social care staff with the knowledge and skills which they need to provide safe, compassionate care.

People said staff were well trained. Care was taken to ensure staff were trained to a level to meet people's current and changing needs. People commented: "I think the staff are well trained" and "The staff know what they are doing." Staff received a range of training, which enabled them to feel confident in meeting people's needs and recognising changes in people's health. They recognised that in order to support people appropriately, it was important for them to keep their skills up to date. Staff received training on subjects including, safeguarding vulnerable adults, the Mental Capacity Act (2005), mental health awareness, physiological conditions, breakaway and de-escalation techniques and first aid. Staff had also completed, or were about to start, varying levels of nationally recognised qualifications in health and social care. Nursing staff kept clinically up to date through various courses and reading evidence based literature. For example, Royal College of Nursing articles.

Staff knew how to respond to specific health and social care needs. For example, recognising changes in a person's physical or mental health. Staff spoke confidently about the care practices they delivered and understood how they contributed to people's health and wellbeing. For example, how people preferred to be supported with personal care. Staff felt people's care plans and risk assessments were really useful in helping them to provide appropriate care and support on a consistent basis.

People were supported to see appropriate health and social care professionals when they needed, to meet their healthcare needs. There was evidence of health and social care professional involvement in people's individual care on an on-going and timely basis. For example, GP, physical health consultants, consultant psychiatrists and mental health practitioners. During our inspection, where people's mental health had deteriorated there was regular contact with professionals and mental health assessments taking place to inform whether hospital admissions would be appropriate. Records demonstrated how staff recognised

changes in people's needs and ensured other health and social care professionals were involved to encourage health promotion. A social care professional commented: "The manager is brilliant. Does everything I say and understands why things are asked to be done. The manager is supported by good staff, caring staff. People are being managed extremely well bearing in mind their complex needs." A Court of Protection officer commented: "I have always had a good relationship with staff at Woodtown House and check on all the clients' finances when I visit. They have always been open with me about issues relating to the clients and we have tried to work together on ensuring that their quality of life is improved as much as possible in the circumstances of each case."

Before people received any care and treatment they were asked for their consent and staff acted in accordance with their wishes. Throughout our visit we saw staff involving people in their care and allowing them time to make their wishes known. People's individual wishes were acted upon, such as how they wanted to spend their time. For example, in the garden and going out shopping and to the bank.

Staff demonstrated an understanding of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. For example, what actions they would take if they felt people were being deprived of their freedom to keep them safe. 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 when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). No one was subject to DoLS at the time of our inspection. However there had been appropriate involvement of the local authority in the past, but on that occasion the application was not authorised.

People's capacity to make decisions about their care and support were assessed on an on-going basis in line with the MCA. For example, where staff were concerned about a person's ability to manage their own finances. People's capacity to consent had been assessed and best interest discussions and meetings had taken place. For example, a best interest meeting had taken place to discuss and assess a person's ability to manage their finances and whether it was safe for them to go out alone.

People were supported to maintain a balanced diet. People commented: "The food is very nice. Always an alternative"; "The food is excellent, we'll get the summer menu soon" and "The food is lovely." People were actively involved in choosing the menu with staff support to meet their individual preferences. A new breakfast club had been started which encouraged people to participate in cooking their own food. A selection of bowls of fruit ready prepared was a new option with the aim being to encourage healthier eating. Care plans and staff guidance emphasised the importance of people having a balanced and nutritious diet to maintain their general well-being. People's weights were monitored to ensure their general well-being and to identify any concerns. People had been assessed by the speech and language therapist team in the past. Speech and language therapists work closely with people who have various levels of speech, language and communication problems, and with those who have swallowing, drinking or eating difficulties. Staff were following their advice and supporting people to eat safely due to their potential choking risks.

Good

Is the service caring?

Our findings

On the first day of our inspection a member of staff was observed supporting a person to eat who had a pronounced tremor in an uncaring and hurried way. This person's care plan noted that they were at risk of choking and that mealtimes should not be rushed. The observation was discussed with the manager who agreed to contact the agency where the member of staff had come from to discuss this. Following our inspection, the manager confirmed they had spoken to the agency so this could be addressed. However this interaction was an isolated event. All other interactions between staff and people were good humoured and caring. Staff involved people in their care and supported them to make decisions. People's comments included: "The staff are lovely, very caring"; "The staff are kind" and "We are a community and get on well."

Staff treated people with dignity and respect when helping them with daily living tasks. One person commented: "I've got my privacy, I can lock my door." We saw that everyone had a key to their bedroom or a key pad so their personal space was preserved. Staff told us how they maintained people's privacy and dignity when assisting with intimate care. For example by knocking on bedroom doors before entering, being discreet such as closing the curtains and gaining consent before providing care. Staff adopted a positive approach in the way they involved people and respected their independence. For example, supporting people to make specific activity decisions. People were completing a variety of activities and accessing the local community during our inspection. One member of staff commented: "We promote independence and empower people to take control of their lives."

Staff supported people in an empathic way. They demonstrated this empathy in their conversations with people they cared for and in their discussions with us about people. Staff showed an understanding of the need to encourage people to be involved in their care. For example, one person enjoyed staff talking to them about things of interest to them; this provided them with reassurance.

Staff gave information to people, such as when activities were due to take place. Staff communicated with people in a respectful way. Staff relationships with people were caring and supportive. Staff spoke confidently about people's specific needs and how they liked to be supported. Staff were motivated and inspired to offer care that was kind and compassionate. Staff demonstrated how they were observant to people's changing moods and responded appropriately. For example, if a person was feeling anxious. They explained the importance of supporting them in a caring and calm manner by talking with them about things which interested them and made them happy. We observed a member of staff speaking to a person who was becoming mentally unwell. They were reassuring them and using distraction techniques in a caring manner. The person settled and continued with their day.

Staff recognised effective communication as an important way of supporting people, to aid their general wellbeing. Positive feedback had been received from a social care professional. They praised staff for their sensitive and caring response to a difficult situation, which required a person to be admitted to hospital due to a deterioration in their mental health.

Staff showed a commitment to working in partnership with people. Staff spoke about the importance of

involving people in their care to ensure they felt consulted, empowered, listened to and valued. They were able to speak confidently about the people living at Woodtown House and each person's specific interests. They explained that it was important that people were at the heart of planning their care and support needs and how people were at the centre of everything. People confirmed they were treated as individuals when care and support was being planned and reviewed. One person commented: "I have a care plan and was involved in planning my care."

Good

Is the service responsive?

Our findings

People received personalised care and support specific to their needs, preferences and diversity. Care plans reflected people's health and social care needs and demonstrated that other health and social care professionals were involved. One person commented: "They asked me what I like and what I don't like. I know my plan is kept in the office."

Care files were personalised and reflected the service's values that people should be at the heart of planning their care and support needs. For example, supporting people to identify specific activities to aid their wellbeing and sense of value. A person had identified how cycling aided their wellbeing; they spent time cycling independently during our inspection.

Care files included personal information and identified the relevant people involved in people's care, such as their GP and consultant psychiatrist. The care files were presented in an orderly and easy to follow format, which staff could refer to when providing care and support to ensure it was appropriate. Relevant assessments were completed and up-to-date, from initial planning through to on-going reviews of care. Staff commented that the information contained in people's care files enabled them to support them appropriately in line with their likes, dislikes and preferences. Care files included information about people's history, which provided a timeline of significant events which had impacted on them, such as, their physical and mental health. People's likes and dislikes were taken into account in care plans. This demonstrated that when staff were assisting people they would know what kinds of things they liked and disliked in order to provide appropriate care and support. The background information contained the useful section entitled 'Relapse Indicators' with details on how staff should respond constructively to any indicators of a relapse, with actions to take. There was evidence that people had been involved in deciding on appropriate treatment action for relapse.

A new system had been brought into place to document the care planning process. It was currently in a transition phase. Although the care plans had a similar structure, the content was different for each one. The manager explained there will be a more consistent approach once the new system was fully adopted. Care plans were broken down into separate sections, making it easier to find relevant information, for example, physical and mental health needs, personal care, behaviour management, social activities and medicines. Staff said they found the care plans helpful and were able to refer to them at times when they recognised changes in a person's physical or mental health.

Activities formed an important part of people's lives. People engaged in a variety of activities and spent time in the local community going to specific places of interest. For example, shopping, cycling, discos, meals out and for walks. A new staff post entitled 'Activity and Recovery Coordinator' had been created. A comprehensive preferences and interest's checklist, with goal setting, had been devised. Completed questionnaires, which used smiley and scowling faces to identify the likes and dislikes, were observed for several people. One person explained how the questionnaire worked in practice: "You put down things you want to do … I said go to the beach…we're going to go sometime this week to do some beach cleaning. I think it works." Another person said: "We've got huge amounts of new activities since (name of coordinator)

came along. We go out a lot more now. We go to a disco on Wednesday nights at (a local activity centre)."

People were being supported to maintain their independence and access community services. For example, one person was regularly taken to the local library. This was in response to them becoming irritable when they were unable to get out to socialise with others. The impact had been that they were now observed to be much more relaxed and their socialising within the home had improved as a result. The person commented: "X (staff member) takes me to the library. I found out why Appledore is called that. It's old English. It's nothing to do with apples!"

Staff recognised that as the service only had one vehicle, it was sometimes difficult to organise social activities as medical appointments had to take priority. The service responded to this by booking a taxi or changing people's timetables. People confirmed that they were given the choice of activities when this happened. For example when a social outing had to be cancelled, people decided to have a barbecue in the garden instead. One person with a physical disability was observed having their nails painted by a member of staff. They praised the staff for their attention to their individual needs: "They know I like to look my best. They know I like my music. I've got a CD player and radio in my room." The service had good links with the local community. There were regular visits to a local social club. Staff were proactive and made sure that people were able to maintain relationships that matter to them. For example, one person said: "They (staff) are very good about keeping in touch with people. I get regular visits from my social worker." Another person said, "I'm going to go out with my brother soon."

There were regular opportunities for people, and people that matter to them, to raise issues, concerns and compliments. This was through on-going discussions with them by staff and members of the management team. People were made aware of the complaints system. A notice on display in the entrance hall explained to people how to make a complaint, how to give a compliment or how to have a query answered. People confirmed that they knew there was a complaints procedure. One person commented: "There's a notice on the wall about that and about the advocate. I haven't used it myself, but I know someone who has, so I think it works well, the system they've got here." The complaints procedure set out the process which would be followed by the provider and included contact details of the provider and the Care Quality Commission. This ensured people were given enough information if they felt they needed to raise a concern or complaint. The service had not received any complaints. However, the manager recognised that if they received a complaint, they would attend to it in line with the organisation's procedure.

Good

Is the service well-led?

Our findings

Staff spoke positively about communication and how the manager worked well with them, encouraged team working and an open culture. Staff said, "If there is any incident the response from the manager is good" and "The support is really good, can be open and honest."

There was no registered manager in post. The manager had started the process of registering, but due to personal circumstances was now not going to proceed with registration. The previous registered manager still worked for the organisation as a clinical director and continued to support the home. We were assured that measures were in place to manage the service whilst they recruited. These measures included, the deputy manager stepping into the role, supported by both the clinical lead and clinical director.

The service had implemented a duty of candour policy to reflect the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Health and Social Care Act 2008 (Regulated Activities) (Amendments) 2015. This set out how providers need to be open, honest and transparent with people if something goes wrong. The management team recognised the importance of this policy to ensure a service people could be confident in.

Team meetings had not been happening on a regular basis between spring and autumn 2015 due to changes in the management structure. However, staff confirmed that they had worked well as a team and supported each other through this period through ongoing discussions. Now, staff confirmed they had regular discussions with the management team. They were kept up to date with things affecting the service via the recommencement of team meetings and conversations on an on-going basis. Additional meetings took place on a regular basis as part of the service's handover system which occurred at each shift change.

People's views and suggestions were taken into account to improve the service. For example, resident meetings and community meetings, which included staff, took place to address any arising issues. The manager also ensured they spent time with people on a regular basis. Surveys had also been sent out to people receiving a service in May 2016. The surveys asked specific questions about the standard of the service and the support it gave people. The manager was now in the process of collating them in order to review and take any necessary actions. They recognised the importance of ever improving the service to meet people's individual needs. This included the gathering of people's views to improve the quality and safety of the service and the care being provided.

The service's vision and values centred around the people they supported. The organisation's statement of purpose documented a philosophy of maximising people's life choices, encouraging independence and people having a sense of worth and value. The organisations philosophy was embedded in Woodtown House.

The service worked with other health and social care professionals in line with people's specific needs. This also enabled the staff to keep up to date with best practice, current guidance and legislation. We observed partnership working throughout our inspection to address concerns about deteriorations in people's mental

health. People and staff commented that communication between other agencies was good and enabled people's needs to be met. Care files showed evidence of professionals working together. For example, GP and consultant psychiatrist. Regular medical reviews took place to ensure people's current and changing needs were being met. A social care professional confirmed that the service worked well with them and took on board things requested.

There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. For example, changes to a person's care plan and risk assessment to reflect current circumstances.   Actions had been taken in line with the service's policies and procedures. Where incidents had taken place, involvement of other health and social care professionals was requested to review people's plans of care and treatment. The service was both responsive and proactive in dealing with incidents which affected people.

Checks were completed on a regular basis as part of monitoring the service provided. For example, the checks reviewed people's care plans and risk assessments, medicines, incidents and accidents and health and safety. This enabled any trends to be spotted to ensure the service was meeting the requirements and needs of people being supported. Where actions were needed, these had been followed up. For example, care plans reviewed and maintenance jobs completed. In addition, a quality assessment had been completed by an external auditor in April 2016. This was completed in line with the Care Quality Commission's 'five questions.' The service was awaiting their report.