Larchwood Care Homes (South) Limited

Wickwar

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 inspection took place on 6 and 7 December 2017 and was unannounced. Wickwar Nursing Home provides accommodation and nursing care for up to 39 people. At the time of our visit there were 26 people living at the service.

At the time of the inspection the registered manager had been on long term leave and they had submitted an application to CQC to de-register as the manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A temporary manager was in post to help ensure smooth running of the service whilst plans were in place to recruit a new manager.

At our last inspection in September 2016 we rated the service overall as Requires Improvement. This was because we found a breach in Regulation 12 and people were not protected from the risks associated with cross infection. In addition we could not be satisfied that good management and leadership of the service would be sustained.

Following the inspection we told the provider to send us an action plan detailing how they would ensure they met the requirements of that regulation. At this inspection we saw the provider had taken action as identified in their action plan and improvements had been made. In addition they had sustained previous good practice. As a result of this inspection the service has an overall rating of Good.

Why the service is rated Good.

Even though there was a temporary manager in post their appointment had already significantly helped improve the previous lack of management of the service. Their previous experience as a manager had equipped them with the skills and knowledge required for their roles and responsibilities. It was evident they were confident and committed to embrace the new challenges and to improve the service. An increase in the provider's oversight meant that a significant number of improvements had been made to help ensure that people were safe and received quality care.

Improvements had been made to help ensure people were protected from the risk of cross infection. This was because appropriate guidance had been followed. People were now cared for in a clean, hygienic environment.

The manager and staff followed procedures which reduced the risk of people being harmed. Staff understood what constituted abuse and what action they should take if they suspected this had occurred. Staff had considered actual and potential risks to people, plans were in place about how to manage, monitor and review these.

People were supported by the service's recruitment policy and practices to help ensure that staff were suitable. The registered manager and staff were able to demonstrate there were sufficient numbers of staff with a combined skill mix on each shift.

Staff had the knowledge and skills they needed to carry out their roles effectively. They felt supported by the manager and deputy at all times. The manager, deputy and nurses had a good understanding of the Mental Capacity Act 2005 (MCA). The care staff understood its principles and the importance of supporting people to make decisions and protect their rights.

People received a service that was based on their personal needs and wishes. Changes in people's needs were quickly identified and their care amended to meet their changing needs. The service was flexible and responded very positively to people's requests. Staff demonstrated a genuine passion and commitment for the roles they performed and their individual responsibilities. It was important to them that those living at the service felt 'valued and happy'.

People benefitted from a service that was well led. People who used the service felt able to make requests and express their opinions and views. Staff were embracing new initiatives with the support of the manager and provider. They continued to look at the needs of people who used the service and ways to improve these so that people felt able to make positive changes.

The provider and manager had implemented a programme of improvement that was being well managed. The manager and provider demonstrated a good understanding of the importance of effective quality assurance systems. There were processes in place to monitor quality and understand the experiences of people who used the service.

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 had improved to Good.

People were now protected from the risk of cross infection because appropriate guidance was followed. The home was clean and odour free.

Staff had received training in safeguarding so they would recognise abuse and know what to do if they had any concerns.

Appropriate action was taken to ensure there were enough staff to support people.

Risks had been appropriately assessed and staff had been provided with clear guidance on the management of identified risks.

People were protected through the homes recruitment procedures. These procedures helped ensure staff were suitable to work with vulnerable people.

People were protected against the risks associated with unsafe use and management of medicines.

Is the service effective?

Good

The service remained effective.

Is the service caring?

Good

The service remains caring.

Is the service responsive?

Good

The service remained responsive.

Is the service well-led?

Good

The service was well led. Improvements required had been identified and plans were in place to rectify these.

Quality monitoring systems were in place and had influenced change and improvement.

The service needed to sustain improvements made to evidence they were effective.

People who used the service felt supported by the management team.

Procedures were in place for recording and managing complaints, safeguarding concerns, incidents and accidents.

Wickwar

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

This service was previously inspected in September 2016. At that time we found there were areas that required improvement. This inspection was conducted over two days by one adult social care inspector who was accompanied by an expert by experience. An expert by experience is a person who has used this type of service in the past.

Prior to the inspection we looked at information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law.

Before the inspection, we had asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they planned to make. We reviewed the information included in the PIR and used it to assist in our planning of the inspection.

During our visits we spoke with 10 people individually in addition to observing people in communal areas. We had the opportunity to meet and speak with two family members. We spent time with the manager, deputy, two nurses and six care staff. We observed lunch and staff interaction with residents, families and each other whilst providing care. We looked at people's care records, together with other records relating to their care and the running of the service. This included staff employment records, policies and procedures, audits and quality assurance reports.

Good

Is the service safe?

Our findings

The service had improved to good. People appeared to be happy, comfortable and safe in their surroundings. We asked people if they felt safe. Comments included, "I do feel safe, I don't particularly know why, they are all very nice to me", Oh yes, it's very good, because you're feeling closed in, somebody's looking after you and they're very caring here", "I feel safe because there are people around and people to look after me", "Absolutely I feel safe. Much more than the other home I was in". The nursing staff are excellent with health problems, I couldn't have wished to come to a better place" and "It is nice to have 24hr care". One relative told us, "Yes, I do think my relative is safe, she always seems to do the things I couldn't get her to do, she's now doing things for herself. They make sure she eats and gets her medicines regularly".

At the inspection of September 2016 we found people were not protected from the risks associated with cross infection because appropriate guidance had not been followed. Although some areas of the home had been clean and fresh, we saw evidence where parts of the home were not clean. In some areas the interior fixtures, fittings and furnishings were not in good physical repair and could not be effectively cleaned. Laminate had peeled off vanity sink units which revealed rough chipboard. Plastic coating on the frames of the commodes and toilet seat raisers had started to peel away to expose rust. Effective cleaning was compromised in these areas and could
harbour germs.

Infection control audits were not satisfactory and had not identified the concerns we had during our visit. The provider and manager were not following the Department of Health, Code of Practice on the prevention and control of infections, or other relevant guidance. These were breaches of Regulation 12 of the Health and Social care Act 2008 (regulated Activities) Regulations 2014.

Following the inspection of September 2016 the provider sent us an action plan detailing how they would resolve the issues we had identified with set timescales to achieve this. Many of the improvements were achieved promptly, including the condemning and replacement of equipment, staff received training in infection control, a revised up to date policy and procedure was put in place, an infection control lead for the home had been identified, deep cleaning schedules were completed and daily spot checks were conducted. This meant that immediate risks to people had been reduced.

A programme of redecoration and refurbishment continued throughout the home so that cleaning was more effective. Infection control audits were completed every month and the area manager also reviewed the environment and infection control measures during their visits. Overall the home was cleaner and free from poor odour. However we did smell urine in one person's room but this had already been identified by the nurse in charge. We heard them speaking with someone to arrange a carpet clean and failing that the flooring was to be replaced. One relative had contacted us after our inspection who had also expressed concerns about a smell of urine when they visited.

The provider had an up to date safeguarding policy in place. Records detailed the local procedure and contacts for the safeguarding team. Staff understood what constituted abuse and knew the processes to

follow in order to safeguard people in their care. Policies and procedures were available and training updates attended to refresh their knowledge and understanding. The manager and staff knew their responsibilities and duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse. Agencies they notified would include the local authority, CQC and the police. Staff knew about 'whistle blowing' and the importance of alerting management to poor practice.

Staff had a good knowledge of risk assessments and measures to be taken to keep people safe. Assessments were undertaken to assess any risks to people, this included environmental risks and any risks due to the health and support needs of the person. Risk assessments provided a helpful guide about the action to be taken to minimise the chance of harm occurring. Examples included the risk of choking, weight loss, falls and prevention of skin breakdown.

Staff understood their responsibilities for reporting accidents, incidents or concerns. Written accident and incident documentation contained information about the lead up to events, what had happened and what action had been taken. Any injuries sustained were recorded on body maps and monitored for healing. Monthly audits helped learning from incidents that took place so that appropriate changes were implemented and measures could be taken to prevent possible reoccurrence.

We asked people if they felt there were enough staff on duty. Overall comments were positive and included, "Good Lord yes, there are plenty of people to help me", "When you press the buzzer, they come reasonably quickly", "The nurses are very good but maybe there are not enough and you may have to wait for things. When they do come they are very good", "Is there enough staff, yes I would have thought so" and "There could be more staff. The staff that are here are excellent. I feel there are times when they need more staff. First thing in the morning, after lunch and settling before bed there can be delays. They can't do everything at once".

The home was registered to accommodate 39 people. At the time of our inspection there were 29 people living in the home and three of these were residential and did not require nursing care. When the home was fully occupied there were always two nurses on duty, at the time of the inspection, due to the reduction in occupancy this had reduced to one nurse. The manager told us staffing levels were continually assessed to help ensure there were the required staff on duty. A dependency tool provided guidance on the staffing levels required to meet the needs of people. The skill mix of staff was also considered when completing the staff rotas this included accommodating less experienced staff who would work alongside more senior, experienced staff.

We had less concerns around the actual amount of staff on duty, but there were potential risks about the lack of permanent staff. Vacant shifts were filled with agency and the manager made every effort to ensure the same agency staff were used to help provide consistency and continuity. There was a recruitment campaign in progress for a new manager, nurses and care staff. The provider had increased staff remuneration as an incentive to fill vacant posts. Safe recruitment procedures were followed at all times. Appropriate pre-employment checks had been completed and written references were validated. Disclosure and Barring Service (DBS) checks had been carried out for all staff. A DBS check allows employers to check whether the applicant has had any past convictions that may prevent them from working with vulnerable people.

The manager informed us of the services medicines policies and guidance. Risk assessments were in place and everyone had a clear plan regarding their medication, any concerns were discussed in the daily meetings. Monthly medication audits were carried out and any requirements from this were added to an action plan, any concerns were reported immediately and action taken. All nursing and senior care staff,

who administered medication had completed an advanced medication level two training and had their competencies were checked by an external assessor.

Policy and procedures to be followed in the event of an emergency were known and understood by people who lived in the home and staff. Staff had received training in fire safety and knew what to do in the event of an emergency. The manager had reviewed personal emergency evacuation plans (PEEP) for each person who lived at the home detailing the support they required to keep them safe in the event of a fire. Health and safety checks were completed on emergency lights, fire control panel, fire extinguishers and smoke detectors. A fulltime maintenance person was responsible to ensure regular upkeep of the home, and continued monitoring of health and safety checks.

Good

Is the service effective?

Our findings

The service remains effective. People told us they thought they were in 'good hands'. Comments included, "They know what they're doing. It's all kept nice and clean", "They know what they're doing. They know my needs" and "I think they know what they're doing especially the trained nurses".

The manager had reviewed the training program. It was identified that some e-learning had lapsed, letters were sent to staff reminding them of the deadline to complete this. A plan for 2018 had been put in place so that staff could make arrangements around family and other obligations.
The deputy had overall responsibility to co-ordinate staff induction. New staff had commenced the care certificate to assist them in having an appropriate induction within the home and around their roles and responsibilities. Each new member of staff was allocated a mentor to support them throughout their induction. One new member of staff told us they felt 'thoroughly supported through their induction' and that 'shadowing a senior staff member had helped consolidate their learning'.

A programme of supervision was now in place and regular appraisals would be established over the coming year. All staff had received one supervision since the manager had been appointed so that they could get to know one another and discuss future supervision requirements. The manager wanted to tailor supervision based on personal preferences of staff and professional experience so that they were meaningful and effective. Other forms of support included, group meetings and competency observations for example, hand washing techniques, effective communication, medicine rounds and respecting dignity and respect. Staff told us they had developed a 'cohesive team, they supported each other and that nothing was too much trouble'.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). 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. In some aspects the manager had identified that staff had limited knowledge of the MCA and DoLS. The DoLS provide a legal framework that allows a person who lacks capacity to be deprived of their liberty if done in the least restrictive way and it is in their best interests to do so. Additional training had been sought and people's capacity assessments had been reviewed. The manager told us they had worked closely with staff when completing these and this had increased their knowledge and understanding.

The meals prepared and served to people were well received. People told us they liked the food and they made choices about what they had to eat. Comments included, "The food is nice enough", "I get a choice but it's not like home cooking", "The food has been very nice up to now" They are quite good with the food. I get plenty. You can always have something if you are hungry" and "I can't fault the food at all". The chef met with people on admission and when requested. One person told us, "I was not eating enough to start with. It was immediately altered when I said I needed more. The chef came to see me and discussed my likes and dislikes. I get enough to eat and drink, I have no complaints".

Lunch was calm and unhurried. Pictorial menus were available, tables were nicely laid and those who required assistance were helped in a respectful dignified way at a pace led by the individual. Drinks and snacks were provided at regular intervals during the day. This was provided in a way which was respectful, caring and demonstrated knowledge of individual likes and dislikes.

Staff continued to support people to maintain a healthy weight and a balanced diet whilst supporting their likes and dislikes. If people were at risk of weight loss staff had management guidelines to assist with developing a care plan and identifying any action required. Food and fluid intake was recorded if required, so that any poor intake would be identified and monitored. People were weighed monthly but this would increase if people were considered at risk. Referrals had been made to specialist advisors when required, including speech and language therapy when swallow was compromised and, GP's and dieticians when there were concerns regarding people's food intake and body weights.

The manager and all staff recognised the importance of seeking expertise from community health and social care professionals so that people's health and wellbeing was promoted and protected. One staff member told us that changes had been made to assist with all visitors to ensure they were prepared with necessary information and that systems were more robust and streamlined. Feeding back to staff and recording the outcomes of the visits had also improved so that key messages were not missed and any action required was carried out. Staff ensured everyone had prompt and effective access to primary care including preventative screening and vaccinations, routine checks, GP call outs and access to emergency services. People were supported to register with GP's, dentists and opticians of their own choice.

Some areas of the building remained tired and in need of updating. The manager had completed an environmental audit of the premises, and had instigated some immediate changes. New flooring has been replaced in some of the bedrooms and the hallways has been decorated. The maintenance person and manager had worked closely together to ensure compliance with health and safety and revised decoration programme had been set for 2018.

Good

Is the service caring?

Our findings

People continued to receive support from a caring service. People appeared to have a good relationship with care staff and they looked comfortable and relaxed when approached. The atmosphere appeared to be good and we observed a lot of friendly, caring interactions, and smiles. Comments from people were positive and included, "The care is good. The carers have a good sense of humour", "I have a great relationship with them, I love them to bits", "The staff are nice. They do their best and they don't do anything I don't want", "The carers are very understanding. They offer advice to the best of their ability and will make changes if I ask. My family are made very welcome. My son comes in and they are wonderful with him".

A relative we spoke with told us, "The staff are nice to my mother. They understand how she needs to be looked after. I am made welcome, all the staff speak to me and I can visit when I want. When I came in the other day I was cold and the staff looked after me".

Staff were proud about how they supported people and felt they received care that was caring and respected individual wishes. Staff comments included, "I think the residents seem a lot happier recently", "I always feel proud when I go home and that we have done our very best", "I know my nan would love it here, she would be looked after well" and "The residents are always at the heart of what we do, yes sometimes we are busy but they always come first and I will not rush them".

During our visits we saw staff demonstrating acts of patience and kindness. Mealtimes were a good example where staff promoted an atmosphere that was calm and conducive to dining. We observed staff speak sensitively to people, they described the meal they served, repeatedly offered drinks and asked if everything was satisfactory. People who required help with eating and drinking were supported with dignity and respect.

People were smartly dressed and looked well cared for. It was evident people were supported with personal grooming and staff had sustained those things that were important to them prior to moving in to the home. This included preferred style of clothes that were clean and ironed, shaving, manicures, helping people to fasten their jewellery and access to weekly visits with the home's hair dresser.

People we spoke with agreed they were treated with respect and dignity, and their privacy was maintained. Many people chose to have their bedroom doors open, and we observed staff calling out as they entered their rooms. Everyone said their dignity was maintained when receiving personal care and confirmed doors were closed and curtains drawn before any personal care was given.

The manager was in the process of introducing a nationally used initiative that puts the 'resident' at the heart of the service and has proven successful with residents, relatives and healthcare professionals nationally. Resident of the Day is an initiative that helps care home staff to really understand what is important to each person and to review in depth what would make a difference to them. Each day, in homes across the region, the resident of the day programme enables all staff, whether carers, nurses, housekeepers or gardeners, time to get to know one service user so that they can personalise their care and provide an

environment for them to enjoy as much stimulation as possible.

Visitors were welcome any time and people saw family and friends in the privacy of their own rooms in addition to small quiet lounge areas in the home. Family and friends were invited to special events.

Good

Is the service responsive?

Our findings

The service remained responsive. During our visits we saw people being cared for and supported in accordance with their individual wishes. People said they made their likes and dislikes known. One person told us, "The nursing staff are excellent with health problems, I couldn't have wished to come to a better place". The manager continued to complete thorough assessments for those people who were considering moving into the home. In addition to the individual, every effort was made to ensure significant people were also part of the assessment. This included family, hospital staff, GP's and social workers. The information gathered was detailed and supported the manager and prospective 'resident' to make a decision as to whether the service was suitable and their needs could be met. The manager demonstrated a sensible, measured approach before taking any new admissions, ensuring the staff compliment, skills, current dependency levels of people living in the home and the environment were satisfactory.

Following a recent audit of care documentation the manager had identified that care plans did not always reflect the needs of people and they were not evidencing the person centred approach that people were receiving. Care documentation had been reviewed and 'tidied up' to help make them less cumbersome and more 'user friendly'. Old documents and records had been archived and new paperwork had been implemented.

We saw that some progress had been made with the care plans. The speed of progress had been compromised due to the lack of permanent staff but the quality of what had been achieved was positive. The plans demonstrated that people had been consulted about how they wanted to live their lives and what level of support they wanted from staff. One person stated in their night time plan that they preferred the light off, the television on and their door left ajar, another person wanted to be checked discreetly by staff but not woken up. A personal care plan we looked at informed staff that one gentleman was happy with male or female carers, he preferred a daily electric shave and expressed what clothes he liked to wear.

Staff shared with us their experiences of the care and support they provided people, they felt they had embraced improvements, that care was much more person centred and residents seemed much happier. One staff member told us, "People are a lot more involved and the care reviews have really helped'. Another staff member spoke with us about how revised lunch times had enhanced people's dining experience, people had more choice as to when they wanted to receive their meal, felt less rushed and that it was a more pleasurable experience.

The activities co-ordinator was not available during the inspection visits. There seemed to be little in the way of activities happening in their absence. We asked people about activities and what they did to occupy their day. Comments included, "I've got my own room and I do what I like. I don't go downstairs as some people are asleep. I've got my knitting, magazines so I'm happy", "I enjoy playing scrabble, other board games and jigsaws, "I like to get my hair and nails done", and"I enjoy going out with my family and it's equally nice to return home, I like my own company and spending time here in my room". One person told us about their love of snooker and they were enjoying watching the finals on television.

One staff member told us how people had firm favourites, such as baking, arts and crafts, bingo, fitness classes and movie days. Visitors also came to the home to provide entertainment and company for example the local church choir, a pianist, the brownies and musical entertainers. Parties were always held and popular for significant events such as Christmas, Easter Valentines and Halloween. A recent party and fundraising event has also been well received for Children In Need day. A church service was held every Sunday afternoon for those who wished to attend and people were supported to visit a church service of their choosing so they could continue with their preferred faith/religion.

When asked who they would speak to if they were not happy, people said they would either speak to their family or a member of staff if they had a problem. One person told us, "They really are good. I just say if anything isn't right and they normally put it right". The service had a complaints policy in place and this was shared with people and families on admission. The daily presence of either the registered manager or the deputy meant people were seen every day and asked how they were. This approach had helped form relationships with people where they felt confident to express their views. It was evident when we were accompanied around the home they knew people well and people were comfortable and relaxed in their company. Small things that had worried people or made them unhappy were documented in the daily records and gave accounts of any concerns raised, how they were dealt with and communicated to staff. This information was also shared with staff in shift handovers.

Good

Is the service well-led?

Our findings

The service had been unfortunate with consistency of managers. This was due to unforeseen circumstances and not a fault of the organisation. At the time of our inspection the current registered manager was on long term absence and in the process of de-registering with CQC. There had been three registered managers and two previous temporary managers in the last six years. Despite this the organisation had always ensured a management presence in the home to lessen the risks associated with inconsistency of leadership. Interviews for a replacement permanent manager was underway at the time of our inspection. The temporary manager and deputy had helped ensure an effective managers lead.

Given the history of managers it was understandable that some people were confused as to who the manager was. However people did say when we pointed out who was overseeing the running of the home, that the current manager was 'on the ball, knows what she is doing and puts things right'. Other people told us, "It's very good the home. I suppose the best thing for me is the food. I would recommend it to friends and give it ten out of ten for quality", "I certainly would recommend the home to my friends and family and give it a nine out of ten for quality", "I do see the manager regularly, about twice a week and I would recommend the home to others" and "I would say ten out of ten for quality. If you want anything they'll help you".

The majority of staff appeared to be well motivated and caring. There was a positivity about the leadership and they felt supported by the manager and deputy. Staff shared how the inconsistencies of management had not been easy but things had been improving. Comments included, "I feel a lot more confident now, we are good at what we do and we have more direction and help", "I can talk to the manager and deputy they are very approachable", "Both the manager and deputy step in to help us when we need them, they lead by example" and "I feel more involved with decision making which is always a good thing".

Effective communication had been key in ensuring staff remained positive and supported. In addition to organised staff meetings, heads of department (HoD) meetings were held, this would include, the manager or deputy, a nurse, a senior care staff member, housekeeping, the chef and the maintenance person .Initially these had been held daily so that the team could to discuss changes, issues within their department and any support required. Over time and as the team became stronger these meetings were reduced to twice a week and were currently taking place once a week. Ad hock/flash meetings were still held as necessary. Staff told us these had been a positive introduction, had improved consistency amongst all staff groups which in turn had a positive impact for everyone who used the service.

One of the first things the manager had instigated when arriving at the home was to overview the Home Development Plan (HDP). The HDP had enabled the manager and deputy to address actions needed for the home to be compliant with not only the previous CQC report but the companies IMPACT Audit. The HDP was also discussed at each HoD meeting. HoD's were given a printout of any actions required within their department and these were discussed at the next meeting to ensure actions had been completed. Any other issues identified on completion of monthly audits were placed on the HDP enabling the prioritising of actions needed and set an appropriate action plan. Clear goals for each department were set and followed through on a weekly basis.

As per company policies, audits were completed throughout the month. Any issues identified were given a time and date to address. Issues were discussed with a HoD or those staff allocated to complete the actions. On completion of audits any issues were also transferred to the HDP to enable the management to follow through on a weekly basis. Any targets not met were discussed and new dates set. When required the regional manager and head office were contacted to support the manager.

The manager, deputy and nurses knew when notification forms had to be submitted to CQC. These notifications inform CQC of events happening in the service. CQC had received notifications from the provider in the 12 months prior to this inspection. These had all given sufficient detail and were all submitted promptly and appropriately. We used this information to monitor the service and ensure they responded appropriately to keep people safe and meet their responsibilities as a service provider.