B Patroo And C Beekarry

Woodthorpe Manor Nursing Home

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 7 June 2016 and was unannounced.

Accommodation and nursing care for up to 30 people is provided in the home over two floors. The service is designed to meet the needs of older people. There were 22 people using the service at the time of our inspection.

A registered manager was in post and she was available during the inspection. 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.

Staff knew how to identify and respond to potential signs of abuse. Systems were in place for staff to identify and manage risks and respond to accidents and incidents. The premises were managed to keep people safe. Sufficient staff were on duty to meet people's needs. Staff were recruited through safe recruitment practices and safe medicines practices were followed.

Staff received appropriate induction, training, supervision and appraisal. People's rights were protected under the Mental Capacity Act 2005. People received sufficient to eat and drink and external professionals were involved in people's care as appropriate.

Staff were kind and knew people well. People and their relatives were involved in decisions about their care. Advocacy information was made available to people. People were treated with dignity and respect. People's privacy was respected and staff encouraged people to be as independent as possible.

People received personalised care that was responsive to their needs. Care records contained information to support staff to meet people's individual needs. A complaints process was in place and staff knew how to respond to complaints.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident in raising any concerns with the registered manager and that appropriate action would be taken. The registered manager was aware of their regulatory responsibilities. There were effective systems in place to monitor and improve the quality of the service provided.

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.

Staff knew how to identify and respond to potential signs of abuse. Systems were in place for staff to identify and manage risks and respond to accidents and incidents.

The premises were managed to keep people safe. Sufficient staff were on duty to meet people's needs. Staff were recruited through safe recruitment practices. Safe medicines practices were followed.

Is the service effective?

Good

The service was effective.

Staff received appropriate induction, training, supervision and appraisal. People's rights were protected under the Mental Capacity Act 2005.

People received sufficient to eat and drink. External professionals were involved in people's care as appropriate.

Is the service caring?

Good

The service was caring.

Staff were kind and knew people well. People and their relatives were involved in decisions about their care. Advocacy information was made available to people.

People were treated with dignity and respect. People's privacy was respected and staff encouraged people to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs. Care records contained information to support staff to meet people's individual needs.

A complaints process was in place and staff knew how to respond to complaints.

Is the service well-led?

Good

The service was well-led.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident in raising any concerns with the registered manager and that appropriate action would be taken.

The registered manager was aware of their regulatory responsibilities. There were effective systems in place to monitor and improve the quality of the service provided.

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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 inspection took place on 7 June 2016 and was unannounced. The inspection team consisted of an inspector, a specialist nursing advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

We also contacted the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with six people who used the service, six visitors, a visiting healthcare professional, a domestic staff member, a laundry staff member, the activities coordinator, the cook, three care staff, two nurses and the registered manager. We looked at the relevant parts of the care records of three people, three staff files and other records relating to the management of the home.

Good

Is the service safe?

Our findings

People told us that they felt safe. A person said, "It's as safe as it gets. [There is] nothing unsafe."

Staff said they had completed adult safeguarding training and there was some more training booked within the next month. They were able to describe the signs and symptoms of possible abuse. They told us they would report any concerns to the nurse in charge or the registered manager and felt concerns would be addressed. Staff were also aware of the procedure for reporting to the local authority safeguarding team.

A safeguarding policy was in place and staff had attended safeguarding adults training. Information on safeguarding was available to give guidance to people and their relatives if they had concerns about their safety. Appropriate safeguarding records were kept.

Risks were managed so that people were protected and their freedom supported. Care records contained detailed risk assessments advising staff what the risks to a person were and how these risks could be reduced. Risk assessments had been completed for each person's level of risk including nutrition, pressure ulcers, falls and moving and handling. Risk assessments identified actions put into place to reduce the risks to the person and were reviewed regularly. When a person had fallen more than once, a falls prevention checklist had been completed to ensure appropriate measures were in place to reduce the risk of further falls.

We saw that the premises were well maintained, generally safe and secure. Checks of the equipment and premises were taking place and action was generally taken promptly when issues were identified. However, we saw that water temperatures were being checked but action had not always been taken when temperatures were recorded as too high in people's bedrooms. Staff told us that this would be addressed immediately and during our inspection contacted a plumber to arrange for the work to be carried out.

There were plans in place for emergency situations such as an outbreak of fire. Personal emergency evacuation plans (PEEP) were in place for all people using the service. These plans provide staff with guidance on how to support people to evacuate the premises in the event of an emergency. An emergency contingency plan was in place to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

We saw documentation relating to accidents and incidents was in place and the action taken as a result, including the review of risk assessments and care plans, in order to minimise the risk of re-occurrence. Falls were analysed to identify patterns and any actions that could be taken to prevent them happening.

We observed staff using moving and handling equipment safely. Hoists were used to move people safely and we saw each person had their own allocated hoist sling. Staff said there was generally enough equipment to meet people's needs but one member of staff said an additional hoist would be useful as the availability of hoists sometimes caused delays in moving people away from the dining table after breakfast. Pressure relieving mattresses and cushions were in place for people at high risk of developing pressure ulcers and

they were functioning correctly. When people required assistance with re-positioning to minimise their risk of skin damage, records of this were completed and indicated they received support in line with their care plan.

Most people felt that there were sufficient staff on duty to meet their needs. A person said, "Oh yes, oh yes … press your button – someone will be there in a flash."

Staff felt there were enough staff on duty to provide the care people required in a timely way. One staff member told us that if another member of staff was absent due to sickness it was often not possible to obtain a replacement and on those occasions they felt short of staff but this did not occur frequently (about once a month). We observed that people received care promptly and there were sufficient staff to keep people safe and meet their needs.

Systems were in place to ensure there were enough qualified, skilled and experienced staff to meet people's needs safely. The registered manager told us that staffing levels were based on dependency levels and any changes in dependency were considered to decide whether staffing levels needed to be increased.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

People told us that they received medicines when they needed them, including pain relief. We observed the administration of medicines and found they were administered safely. Staff checked the medicines against the medicines administration record (MAR) and stayed with the person until they had taken their medicine.

Systems were in place for the timely ordering and supply of medicines and we did not find any gaps in the MARs to indicate medicines had been missed due to a lack of availability. MARs had been completed consistently indicating people were receiving their medicines as prescribed. Each MAR chart had a cover sheet with a photograph of the person to aid identification, information about any allergies and details of how they preferred to take their medicines.

Protocols were mostly in place to provide additional information about the administration of medicines which had been prescribed to be administered only as required. However, there were no protocols in place for people's anticipatory medicines which had been prescribed to be given to alleviate symptoms at the end of life. The registered manager agreed to put these in place.

Medicines were stored safely and in line with requirements. We found cupboards, refrigerators and trolleys used to store medicines were locked and were situated within locked rooms. The temperature of storage areas were monitored daily and were within acceptable limits.

Staff told us they had completed training in relation to medicines administration. A nurse told us they had been observed administering medicines when they first started at the home and had had time to familiarise themselves with the people using the service and their preferences for taking their medicines. Medicines audits had been completed and when issues were identified we saw actions had been taken to address them.

Good

Is the service effective?

Our findings

People told us that staff were sufficiently skilled and experienced to support them. A person said, "Oh yes, second to none. You can put money on that." We observed that staff competently supported people.

Staff felt supported. We talked with two staff members who had started work at the service within the last year. They both told us they had been allocated initially to shadow an experienced member of staff and later worked alongside other staff, to ensure they gained a good understanding of people's needs. They said they had had supervisory meetings during their employment. They told us they had completed some mandatory training and were continuing to attend further training when it was available. One person said they were undertaking a nationally recognised qualification through an apprenticeship.

Staff told us they had supervision approximately every two months and an annual appraisal. Staff felt they had the knowledge and skills required for their job role. We saw some completed supervision and appraisal documentation which showed a range of issues discussed by staff. Training records showed that staff attended a wide range of training including equality and diversity. Systems were in place to ensure that staff remained up to date with their training.

People told us staff asked them before providing care. A person said, "Staff ask, 'Would you like to do so and so?'" We saw staff asked permission before assisting people and gave people choices. Where people expressed a preference staff respected them.

On admission to the home a consent form for decisions such as the use of photographs in the care record, the sharing of information with other professionals had been completed. Consent for the administration of medicines by staff was also recorded. When bed rails were being used consent to their use was recorded.

When a lasting power of attorney was in place for a person, for health and welfare, a copy of this was kept in the person's care record and we saw their consent forms had been signed by the attorney and there was a record of their involvement in developing the person's care plans.

The Mental Capacity Act 2005 (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 interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

When people were not able to make some decisions for themselves a statement was made about the fact

they lacked capacity to make the decision but there was no formal assessment to demonstrate how this had been determined.

However, documentation about the best interest decision making process had been completed and provided a good level of detail as to the reasons for the decision. The registered manager agreed to review this area to ensure that the assessment of capacity was more fully documented so that people's rights were fully protected.

DoLS applications had been made for a number of people who used the service. Staff had an understanding of the MCA and how it affected their work.

Where a person had behaviours which other might find challenging, there was a mental health care plan in place which described the behaviour and action to be taken by staff in response. However, we heard they were also reluctant to accept personal care at times and responded better to some staff than to others, and information about this and how it was best managed, was not included in the care plan. The registered manager agreed to add this information to the care plan.

We saw the care records for people who had a decision not to attempt cardiopulmonary resuscitation (DNACPR) in place. There were DNACPR forms in place and these had been completed appropriately. They indicated the involvement of people themselves in the decision and a close relative. We saw a person's capacity to make the decision about the use of CPR had been considered and confirmed.

People told us that they had enough to eat and drink and were happy with the quality of food. A person said, "Second to none; I've never heard a complaint." Another person said, "Excellent. It's the best thing about the place." We saw that people were offered drinks throughout the inspection.

People told us that they had choices regarding what they had to eat. A person said, "They'll find you something you like." Another person said, "I get what I want to eat."

We observed the lunchtime meal. Some people remained in the lounge for lunch and we observed lunchtime for these people. Small tables were used and a tray and cutlery were placed in front of the person in readiness for their meal. They were offered a choice of drinks to have with their lunch. People were served individually and when they required assistance, staff sat alongside them and explained what was on the plate in a positive way, and chatted to them encouragingly. People were able to progress at their own rate and there was a relaxed but efficient approach to serving people.

Menus were available in the dining room and in people's rooms. We saw people had a choice of food and saw this was not confined to the meals on the menu. For example we overheard the cook saying to one of the staff, "[Person's name] is having a cooked breakfast for lunch," and the staff responding, "I'll ask him if he wants some soup first."

People were weighed monthly. We saw some people who used the service were underweight or had been losing weight for several months. However, the dietician and/or speech and language therapist had been involved and steps taken to maximise their nutritional intake including using nutritional supplements and fortifying their food.

When people were at risk nutritionally, a record of their food intake was maintained. Fluid charts recorded people's fluid intake as necessary and were totalled daily. The records we checked indicated people were achieving a good fluid intake. When a person was reluctant to drink and their fluid intake was compromised

a 'hydration buddy' system had been developed to ensure they were offered frequent drinks.

People told us that they saw their GP. They also told us that they saw a chiropodist and a person told us that they could see a dentist if they needed to.

We found good evidence of people's access to healthcare. For example, a person had had cataract surgery at the local hospital and the discharge instructions were available in their care records to ensure staff were conversant with their needs. We saw the dietician and speech and language therapist had been involved when a person was having difficulty eating and drinking and regular contact with the dietician was maintained when a person continued to lose weight. There was evidence of review by other specialist services such as the community neurology service, continence services and physiotherapist.

A person with diabetes had had an annual diabetes review. A chiropodist specialising in diabetes had also attended the person but the records relating to this had not been maintained and we found there had been a four month gap in chiropodist visits. Their care plan indicated they needed to see a chiropodist every six weeks. The registered manager told us shortly after our visit that they had contacted the chiropodist and as a result, had updated the care plan to reflect that the visits take place every three months not every six weeks.

Good

Is the service caring?

Our findings

People told us that staff were caring. A person said, "Yes. Kind … wonderful and marvellous lovely." Another person said, "Definitely. They help you so much." A visiting healthcare professional told us that staff were caring.

Staff were kind and caring in their interactions with people who used the service. We observed some very positive reactions by people using the service towards staff. For example one person who had shown very few signs they were aware of their surroundings, smiled broadly at a member of staff and reached out to hug the staff member when they approached them and spoke to them directly.

Staff knew people well and they related well to people, acknowledging them as they walked into a room and checking on their wellbeing. We saw people were happy and relaxed with staff and enjoyed their company. A visiting healthcare professional told us that staff were very knowledgeable of people's needs.

Some people and most visitors told us that they had been involved in discussions about care. A person said, "Yes, you get little talks about it." A visitor said, "[Staff] really do try to find out [about people's needs] before admission."

Throughout our observations we saw people being offered choices, whether this was in relation to the drinks they preferred that day or where they wished to sit and what they wanted to do with their time. Where people could not communicate their views verbally, their care plan identified how staff should identify their preferences and staff were able to explain this to us.

We saw that families had been asked to contribute to information about the person's previous life history and personal information about them to enable staff to improve their knowledge of the person and what was important to them.

Care plans were person-centred and contained information regarding people's life history and their preferences. A guide for people who used the service was in place and contained information for people on what they should expect from the service. Advocacy information was also available for people if they required support or advice from an independent person.

People told us they were treated with dignity and respect. One person said, "Definitely, all staff are respectful. It's like being the queen." We saw people being treated with dignity and respect. We observed when people were moved using a hoist, care was taken to support them and ensure they were covered using a towel or blanket to protect their dignity. We saw staff took people to private areas to support them with their personal care and the home had a number of areas where people could have privacy if they wanted it.

Staff told us that when they went into a person's room they always knocked first and introduced themselves so that people knew who it was. Staff were able to identify the steps they took to protect people's privacy and dignity during personal care such as closing the doors and curtains and covering people as much as

possible.

We saw that staff treated information confidentially and care records were stored securely. The language and descriptions used in care plans showed people and their needs were referred to in a dignified and respectful manner. Staff had been identified as dignity champions. A dignity champion is a person who promotes the importance of people being treated with dignity at all times.

Staff told us they encouraged people's independence where possible. We saw staff prepared the insulin injection for a person and the person administered the injection themselves. A risk assessment had been completed in relation to this, which enabled the person to maintain their independence whilst ensuring they were safe and competent to complete this task.

Visitors told us they visited regularly, at any time, without appointment. Staff told us people's relatives and friends were able to visit them without any unnecessary restriction.

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs. We saw that staff responded promptly to people and call buzzers were answered quickly.

People told us that they did the activities that they wanted to do. A person said, "I watch TV and read books. I don't do anything else, that's my choice." We observed the activities coordinator engaging people in one to one activities and small group activities such as throwing bean bags into a container. Staff felt people had access to activities and mentioned occasions when people had been on visits outside the home but these did not appear to be frequent. Another staff member said they felt there was a good choice of activities including board games and dominoes. The activities coordinator had recently started at the home and we saw that plans were in place to improve the range of activities offered both inside and outside the home.

Care plans were in place to identify people's care and support needs in relation to the activities of daily living. These provided information about the person's preferences and had been reviewed monthly. Care records contained information regarding people's diverse needs and provided support for how staff could meet those needs. Care plans were also in place to identify people's health needs such as diabetes. These generally provided clear information and were reflective of people's current needs. There were a small number of instances where we found that further detail would have been helpful or the care plan had not been adjusted to take account of changes.

For example, a person's care plan stated a specific pressure relieving mattress was to be used and the weight setting for the mattress was identified. However, we found a different mattress was in place and the settings for this type of mattress were different. It was appropriate for use, as it was an equivalent mattress from a different manufacturer and the setting was correct for the person, however, it could have caused confusion for staff and there was a risk of the mattress being set incorrectly as the mattress setting required was unclear. Guidance for staff on the signs and symptoms of low and high blood sugar levels and the monitoring readings which required action to be taken by staff would have been helpful in a person's diabetes care plan. People's care records contained some printed information from the internet on their health conditions, to enable staff to obtain a fuller understanding of the condition and its potential impact on the person.

People told us that they would complain if they needed to. A person said, "I'd tell the manager." Another person explained that they had made a complaint and it had been dealt with to their satisfaction. Staff told us that if a person wanted to make a complaint they would normally direct them to the nurse in charge or the registered manager as it was important senior staff were aware of issues raised by people. They said they received feedback about complaints at handover or in staff meetings.

Complaints had been handled appropriately. Guidance on how to make a complaint was in the guide for people who used the service and displayed throughout the home. There was a clear procedure for staff to follow should a concern be raised.

Good

Is the service well-led?

Our findings

People could not recall receiving surveys or attending meetings to discuss their views. However, a person told us they felt involved in the home and we saw that meetings had been held to provide people who used the service and visitors with the opportunity to provide feedback on the quality of the care provided by the service. We saw that a suggestion box was in the main reception. We also saw that surveys had been completed by people who used the service and visitors. Responses were positive. The registered manager told us of the steps they had taken to involve people when they chose the colour schemes for the home and the furnishings.

A whistleblowing policy was in place and contained appropriate details. Staff told us they would be comfortable raising issues using the processes set out in this policy. The provider's values and philosophy of care were in the guide provided for people who used the service and displayed in the home. Staff acted in line with those values.

People told us they were content with the atmosphere of the home. Staff told us there was a happy atmosphere. One staff member said, "It is the best home I have worked in. All the staff are friendly and put the residents first." Another said, "It is mostly very happy. We do feel a little bit down when one of the residents passes on, as we have got to know them so well and we miss them." Another staff said they felt they could, "Take the extra time with people." They said people who used the service became very close to the staff and engaged with them well.

People had mixed views about the management of the home. People did not raise any concerns about the registered manager; however, people's views were more mixed regarding another member of the management team. Some people felt well supported by them, while others, felt the staff member could be a bit abrupt and grumpy especially when they were busy. We raised this issue with the staff member and the registered manager, who agreed to review this.

Staff told us they felt the leadership of the home was good. Staff told us the registered manager was very approachable and when they had raised a concern with them they had dealt with the issue. There were frequent staff meetings and staff said they felt able to raise issues and contribute to the agenda at the meetings. We saw that the registered manager had clearly set out her expectations of staff. Staff told us that they received feedback in a constructive way.

A registered manager was in post and was available during the inspection. She clearly explained her responsibilities and how other staff supported her to deliver good care in the home. We saw that all conditions of registration with the CQC were being met and statutory notifications had been sent to the CQC when required. The current CQC rating was clearly displayed in the home and on the provider's website.

The provider had a system to regularly assess and monitor the quality of service that people received. We saw that regular audits had been completed by the registered manager and also by representatives of the provider. Audits were carried out in a range of areas including medication, infection control, care records,

catering and domestic cleaning. Actions took place in response to any identified issues.