Four Seasons 2000 Limited

Woodbury House

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

This inspection took place on the 28 and 30 September 2015. The inspection was unannounced on day one and announced on day two.

Woodbury House is a care home which is registered to provide care with nursing for up to 45 people, including people who live with dementia. At the time of our visit 30 people were using the services. The home is a large detached Victorian building in a country location, not far from the shops and amenities of Wokingham, Reading and Camberley. People had their own bedrooms and use of communal areas that included enclosed private gardens.

The people living in the home needed residential or nursing care and support from staff at all times and have a range of care needs. These included dementia care and palliative care.

The home has not had a registered manager since the 23 December 2014. However a manager who works full-time within the home has applied to CQC to become the

Summary of findings

registered 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.

Staff knew how to recognise and report any concerns they had about the care and welfare of people to protect them from abuse. The recruitment and selection process helped to ensure people were supported by staff of good character and there was a sufficient amount of qualified and trained staff to meet people's needs safely. There were processes in place to ensure people received support from staff to have their medicine on time and safely.

People were provided with effective care from a dedicated staff team who had received support through supervision, staff meetings and training. Staff were supported to receive the training and development they needed to care for and support people's individual needs.

People's care plans detailed how they wanted their needs to be met. Staff were in the process of transferring these to a new person centred format.

There were some omissions within daily monitoring records that had the potential to place people at risk from less effective action being taken from the information that was available. However, other records fully identified people's needs and how these were being monitored to ensure effective care was provided.

Risk assessments identified risks associated with personal and specific health related issues. They helped to promote people's independence whilst minimising the risks. Staff treated people with kindness and respect and had regular contact with people's families to make sure they were fully informed about the care and support their relative received.

The environment had not been designed or adapted to support or enhance the lives of people living with dementia, as it did not assist them to engage, orientate themselves or recognise areas within the home. There were plans to refurbish the home. However, the home was in need of some immediate redecoration and refurbishment and this had been actioned by the provider.

The service had taken the necessary action to ensure they were working in a way which recognised and maintained people's rights. They understood the relevance of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) and consent issues which related to the people in their care. The Mental Capacity Act 2005 legislation provides a legal framework that sets out how to act to support people who do not have capacity to make a specific decision. DoLS provide a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm.

There were not as many activities or outings for people as they would like to see. This had been raised by people at residents' and relatives meetings. They were confident that action would be taken by the manager who they said, "listens". An activities assistant had been appointed who was scheduled to attend specialist activity training together with the manager and another member of the staff team to improve the quality of activities for people. Staff were responsive to call bells and peoples requests for support. People's families told us that they were very happy with the care their relatives received and had noted marked improvements of ensuring they were fully informed since the manager came to the service.

People received good quality care. The provider had an effective system to regularly assess and monitor the quality of service that people received. There were various formal methods used for assessing and improving the quality of care.

Summary of findings

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 protect people from abuse.

People's families felt that people who use the service were safe living there.

The provider had robust emergency plans in place which staff understood and could put into practice.

There were sufficient staff with relevant skills and experience to keep people safe.

Medicines were managed safely.

Is the service effective?

Requires improvement 

The service was not always effective.

There were some omissions within the records such as re-positioning and topical medicines charts.

The environment had not been designed or adapted to support or enhance the lives of people with dementia. Areas of the home were in need of redecoration and refurbishment.

People's individual needs and preferences were met by staff who had received the training they needed to support people.

Staff met regularly with their line manager for support to identify their learning and development needs and to discuss any concerns.

People had their freedom and rights respected. Staff acted within the law and protected people when they could not make a decision independently.

People were supported to eat a healthy diet and were helped to see G.Ps and other health professionals to make sure they kept as healthy as possible.

Is the service caring?

Good 

The service was caring.

Staff treated people with respect and dignity at all times and promoted their independence as much as possible.

People responded to staff in a positive manner and there was a relaxed and comfortable atmosphere in the home.

Is the service responsive?

Good 

The service was responsive.

Staff knew people well and responded quickly to their individual needs.

Summary of findings

People's assessed needs were recorded in their care plans that provided information for staff to support people in the way they wished. These were being reviewed and new formats of person centred care plans were being implemented.

Activities within the home were provided for each individual. These were being further developed alongside staff training.

There was a system to manage complaints and people were given regular opportunities to raise concerns.

Is the service well-led?

Good

The service was well-led

People who use the service and staff said they found the manager open and approachable. They had confidence that they would be listened to and that action would be taken if they had a concern about the services provided.

The manager and provider had carried out formal audits to identify where improvements may be needed and acted on these.

Woodbury 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 inspection took place on 28 and 30 September 2015 by three inspectors on day one that was unannounced and by two inspectors on day two that was announced.

Before the inspection we looked at an action plan that the provider had produced following concerns raised about the service in July 2015. This detailed some key information about the service, what the service does well and improvements they plan to make. We also looked at all the information we have collected about the service. The service had sent us notifications about injuries and safeguarding investigations. A notification is information about important events which the service is required to tell us about by law.

During our inspection we observed care and support in communal areas and used a method called Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We spoke with 10 people who lived in the home and six relatives of people who use the services. We spoke with the manager of the home, clinical facilitator, regional manager, regional health and safety manager, property manager and eight staff. We also received feedback from local authority social care professionals, GP, NHS Home Care Support Team and Fire Officer.

We looked at nine people's records and records that were used by staff to monitor their care. In addition we looked at five staff recruitment and training files. We also looked at accident and incident reports, a sample of policies, duty rosters, menus and records used to measure the quality of the services that included health and safety audits.

Good

Is the service safe?

Our findings

Safeguarding concerns reported July 2015, were being investigated under multi-agency safeguarding procedures at the time of this inspection. Professional meetings had taken place following those concerns that had agreed an immediate recovery plan with the provider to ensure safe and good quality of care for the people who use the service.

The provider had shared appropriate information of the safeguarding concerns, without compromising the investigation, with people and their relatives at a meeting on the 5 August 2015. The provider continued to be open and transparent throughout the process of investigation sharing information as requested, whilst working in partnership with professionals to promote people's safety and well-being.

People told us they felt safe. Comments included: "It's nice and safe here" and "the staff are marvellous. They keep me safe and secure". A relative told us, "I rest easy at night knowing my wife is well looked after and kept safe". Another relative said, "yes I feel she is safe".

Staff were able to provide a robust response in relation to their understanding of safeguarding. They had received on line training and told us that this had made them more aware of what constitutes abuse and how to report concerns to protect people. Staff made reference to the organisation's whistleblowing policy and stated if they were not listened to by the manager or within their organisation they would report their concerns to the local safeguarding authority or Care Quality Commission (CQC). Comments from staff included: "we are at this moment very aware of such things. We would speak to the home manager and escalate this if needed as I work for the people in the first instance only".

People were supported by staff who had been recruited as safely as possible. Staff files contained relevant documentation to check identity, previous employment, competence and character, together with criminal record checks. Application forms were required and records of interviews were maintained.

Staff told us that there were enough staff on duty to carry out their duties and to spend a little extra quality time with residents. However, difficulties did arise when staff called in sick at short notice. Staff did say that on these occasions the manager was very good at getting agency cover. The staff rota was reviewed on 8 September 2015. The records identified sufficient trained and skilled staff had been scheduled to work to meet the needs of the people who lived in the home. In addition, the provider had employed a 'Clinical Facilitator' to work at the service and provide support to the manager and staff whilst improvements were being introduced. We were informed that agreement had been reached for the clinical facilitator to remain full-time in the home for a further four weeks to support the new manager through the improvements. The agreement would be reviewed at the end of the four week period. Comments from staff included: "We have enough staff now, it makes a difference in the morning and evening to have enough staff; it's more organised".

People were given their medicines safely by staff who had received training in the safe management of medicines. Staff competency assessments were completed. These assessments were signed off by the assessor and dated when in agreement that the staff member was competent to support people with their medicine. A chief pharmacist from an NHS Clinical Commissioning Group (CCG) was scheduled to deliver training to staff on the 26 October 2015.

The service used a monitored dosage system (MDS) to support people with their medicines safely. MDS meant that the pharmacy prepared each dose of medicine and sealed it into packs. The medication administration records (MARs) were accurate and showed that people had received the correct amount of medicine at the right times. Staff used the Abby Pain Score (an observational pain assessment tool used in the care of people with dementia who may not be able to verbally communicate that they are experiencing pain). Staff told us that medication prescribed for pain as and when required (PRN) was reviewed when a person had required the medication for three consecutive days.

We saw accident and incident records which did correspond with people's records such as care plans. We were told and were shown an auditing tool which was used to capture all relevant occurrences including accidents and incidents. The auditing tool was used to track, follow up and identify any trends. This was designed to ensure that any action taken focussed on the prevention of further occurrences.

Good

Is the service safe?

We saw minutes from a health and safety committee meeting held on 25 September 2015. These were held periodically and enabled discussion and actions to be identified in relation to a wide range of health and safety issues including, risk assessments, trips, slips and falls, accidents, training and security.

On the 15 September 2015 a Fire Safety Inspecting Officer visited Woodbury House, to assess the fire safety procedures. We spoke with the officer prior to our visit who informed us that they were arranging to meet with the manager: "to discuss their action plan and move forward". They informed us that there were areas that the service needed to address. During our visit the fire officer had met with the provider's property manager to discuss horizontal and vertical evacuation plans. They also discussed and agreed a contingency plan whilst the provider worked towards the provision of vertical evacuation equipment. Bedroom fire risk assessments were being reviewed to identify each person's needs to be supported to evacuate the building.

Requires improvement

Is the service effective?

Our findings

People and their relatives described staff as, “professional”, “caring” and “very knowledgeable”. Other comments included: “they use a hoist for me; I'm not frightened as it is quite comfortable”. A relative also stated: "I like the atmosphere here, it is calm and quiet, it is what she needed – they did speak about refurbishment".

Members of a local NHS care home support team had provided targeted training covering topics such as pressure ulcers and wound care. We saw documentation that confirmed this training had taken place. Comments from the NHS care home support team included: “I would absolutely say that they are making headway; now I can say we have happier engaged staff".

Staff described the staff team as supportive and working well. Comments included: “We are really growing and getting amazing support that includes one-to-one training with (name of clinical facilitator and NHS homecare nurse). “I seriously feel I have a great amount of support; I want to see it through and see the difference".

There was a comprehensive induction programme designed for staff at different levels of responsibility. Staff training records were largely held electronically with some paper certificates stored on individual staff files. New systems for recording and accessing staff training was being introduced. It was therefore, not possible to see a clear overview of all the training undertaken by the staff team. Staff told us that they did have access to training which included e-learning, group and individual discussion.

Staff were scheduled to attend training on the Mental Capacity Act 2015 (MCA). Consent, mental capacity and Deprivation of Liberty Safeguards (DoLS) were understood by the manager. The manager had submitted appropriate DoLS applications and told us she had recently submitted some applications to the local authority for up-dated authorisations. People were provided with an independent representative under DoLS as required.

Part of the Safeguarding Investigation had identified some issues with the recording of care for some people with compromised skin integrity. A clinical facilitator employed by the provider to support and promote staff learning and development stated: “I am confident we are dealing with people’s skin integrity” and explained processes that were in place to monitor and promote effective care.

People’s health needs were met. People were assisted to make appropriate appointments with the GP and other health care professionals. Examples included referrals to the dietitian, tissue viability specialist and the speech and language team (SALT). Care plans included people’s health and medication needs and records of any appointments or healthcare visits. Visiting professionals’ comments and the outcome of the visits were included in the records.

Daily repositioning, food and fluid and bowel movement charts were kept, as necessary, for the individual. They were mostly completed accurately, as instructed in the plans of care. For example if people needed turning two to three hourly or needed an hourly safety check, these were completed and recorded. However, there were some omissions within the records we looked at such as re-positioning and topical medicines charts; these were mostly due to duplication of records

People’s care needs were included in their individual care plans. Areas of care included diet and nutritional needs, health needs and cognition needs. The plans described the action staff were to take to meet people’s individual needs. However, care plans were complex and contained repetitive information. On occasion, because the same information was in several places, not all the information ‘matched’.

All staff were receiving regular one to one support from their line manager. We were told by the management team that annual appraisals had not been introduced fully but would be implemented according to company policy at some point in the near future. Regular staff meetings were held and individual staff felt confident to raise issues for discussion. Staff meetings were arranged to include care staff and nursing staff at separate meetings. A whole team meeting had been held since the appointment of the new manager in July 2015.

People were given a choice of food for their breakfast and time to make their decision. They were helped to eat in a pleasant and relaxed atmosphere. For those requiring intensive support staff sat next to people and provided appropriate and sensitive encouragement for them to enjoy their meal in their own time. Staff used appropriate

Requires improvement

Is the service effective?

humour and touch and displayed patience at all times. They encouraged people to eat by giving positive praise and using distraction techniques. People told us that there was always plenty to eat and food was freshly prepared. One person told us that the flavouring is not good; "not like how I cook".

People were provided with food which met their individual needs and choices. For example the service provided suitable diets for people with diabetes, people who chose to be vegetarian and for those who needed soft or pureed options. At the time of the first visit the heating was on despite it being a warm day. This was due to a fault with the system which was expected to be remedied the following day. Staff had responded to the temperature by ensuring that people had sufficient to drink. They were observed providing and encouraging people to drink squash or alternatives throughout the duration of our visit.

People living with dementia were accommodated in the 'Memory Unit' on the first floor. The unit was in need of redecoration and refurbishment. Paint was chipped and an old stained carpet created an unpleasant, underlying smell, which pervaded the communal area. The environment had not been designed or adapted to support or enhance the lives of people with dementia. Parts of the environment did not assist them to engage, orientate themselves, or, recognise their bedroom. The communal space was limited consisting of a small sitting room and a separate dining area. People did not have independent access to other areas of the home.

Current best practice guidelines had not been followed in order to help people identify and distinguish their bedrooms independently, although some people had their photographs on their bedroom doors. For example: bedroom doorframes or doors were not distinguished from the corridor by colour and there were no memory boxes.

Toilet doors did not distinguish them from their surroundings to assist people to locate the toilet. There were limited reminiscence items and pictures in communal areas, to stimulate or engage people with dementia. However, the dining room did have pictures relating to food and eating which helped orientate people and encouraged them to eat. The menu was not in a format which would help people to choose or identify the food they were being offered.

The registered manager told us they had researched environments suitable for people living with dementia and were adopting some improvements recommended by a nationally recognised dementia care organisation. A refurbishment programme for the building had also been placed on hold by the manager to allow time for the quality of care practice to be developed to an acceptable level. In response to findings from the first day of the inspection new carpeting, curtains and repainting to the communal areas of the home had been commissioned. In addition, work to upgrade the first and ground floor bathrooms had been put to tender.

Good

Is the service caring?

Our findings

People told us that staff treated them with kindness and patience. Other comments included, “it’s a very happy place” and “they all look after you and respect you”.

Staff spoken with provided a good account of individual peoples’ needs. Visiting professionals also told us that staff were welcoming and could provide appropriate updates about peoples’ changing needs. One professional said, “Staff are respectful and caring; families I have spoken with from reviews were highly respectful of them”. Another professional said, “they (staff) had different training last week (referring to dignity week) for example, putting glasses on that were smeared to see how it feels”.

We were told that ‘Dignity Week’ was held in the home between 21 and 25 September 2015. This is where the service challenged staff to experience how it would feel to be in your pyjamas all day, to wear glasses that were smeared, not to be offered a drink, to be assisted with personal care and not to be talked to whilst the task was being carried out. This was followed by a reflection day “what would you change in your practice”. Staff told us that this had been a really good week that had given them a heightened awareness on how a person's dignity could be disrespected. One member of staff said, “it was a real eye opener". A visiting GP also made reference to dignity week and said, “I had advised staff to drink a warm ensure (food supplement) to see how that would taste informing them that it was much nicer served cold”.

People were encouraged to express themselves and make decisions, if they were able to. Staff described what they were doing and why and people were asked for their permission before care staff undertook care or other activities. When people were being supported to transfer to a wheelchair or to a dining chair staff explained what they were doing and provided encouragement and guidance to them. People were not always able to respond to staff but allowed them to continue with the task. For example, one member of staff apologised profusely to a person when they had to take time to ensure a ‘lifting’ device was properly in place.

A survey conducted by the service indicated that 60% of relatives felt involved with the care provided to their relatives. One relative said, “I visit the home regularly and have never felt there were any problems; I’ve always felt they were looking out for them". Another relative said, "(named nurse) has been marvellous; very caring attitude".

Throughout the inspection staff were seen addressing people appropriately in a warm and friendly manner. One relative told us that they knew that, “in the night when staff check on (name) they always say who they are and what they are doing so as not to frighten or startle her”.

People’s wishes for end of life care where obtained and were recorded in the appropriate section of their care plan. One person who had capacity had made the decision that they did not wish to be resuscitated. This decision was clearly recorded in their care plan. Do not resuscitate forms (DNACPRS) were appropriately completed and signed by the GP, where appropriate.

Good

Is the service responsive?

Our findings

People's needs were assessed before they moved in to the service.

Care plans included areas called, ''what is important to me'', ''a good day'' and, ''a bad day''. The information within these sections ensured staff could respond appropriately to people's individual preferences. For example, one person's record stated, "I like music and for it to be sunny and light". We observed that the person remained in their bed throughout the day due to their assessed needs; music was playing in the background and the person's bed had been positioned to have the full benefit of the light that came through the large windows within the room. People's religion and beliefs were noted.

The care plans were in the process of being transferred to a new format in line with the providers' requirements. It was acknowledged that accessing relevant information without the use of tools such as dividers was not easy for people unfamiliar with the system. However, all significant information for each person being supported was contained within the records seen. Areas of need included personal care, skin integrity and wound care, communication, social interaction and mood, choices and preferences, sleep and cognition.

A member of the NHS care home support team spoke of improvements that have been made whilst they have been supporting the service. They told us "care plans were now reflective of the individual" and that "they (the provider) now have the new care plans, although these are in draft". A social worker told us that they had visited the home unannounced and said, "I was sat out of the way so that I could discreetly observe. I overheard positive remarks amongst staff to ensure people's needs were met". Another visiting social worker said, "I viewed a hoist transfer that corresponded with the person's care plans that stated full body hoist and two care staff".

A separate record had been introduced which included all those people who had some issue with their skin integrity; this included the first recognition of any reddening of the skin. This had provided an effective management monitoring tool to ensure that an overview of people at risk was maintained for the home as a whole.

A brief handover sheet was used to detail the basic health and social care needs of each person and any significant changes in their wellbeing. There was evidence from documentation and from speaking to people that external health care professionals were consulted and appropriate referrals were made when people's needs changed. Care plans included a section on recording the interventions of visiting health care practitioners where their recommendations were clearly recorded.

People and their relatives told us that there were not many activities or outings for people as they would like to see. Their viewpoint on this had also been recorded within the minutes of residents and relatives' meetings. A new activities coordinator had been recently appointed and specialist activity training had been booked for this individual together with the manager and another member of the staff team to improve activities for people.

Throughout the visit we observed that staff responded to call bells in a timely manner. All call bells were answered in less than one minute. One person told us that, "staff come pretty quickly". However, a relative said, "I'm not sure about the night staff as (name) has had to call a few times in the night and told they have not got the time. We have informed the manager and her keyworker and feel we will be listened to as I have spoken with the manager before with minor issues and those were addressed".

A record of complaints was maintained. The record seen clearly recorded the nature of the complaint, the action taken and the outcome that had been achieved. A record called "you say, we did" had been introduced to demonstrate what the service had done in response to peoples comments and concerns.

Good

Is the service well-led?

Our findings

There was a manager at Woodbury House who had submitted an application to the Care Quality Commission (CQC) to become the registered manager.

People were able to express their views. For example, a relative of a person said; “they do have relative meetings”. Another said, “The manager had made herself known at a residents and relatives meeting. The minutes of a meeting held in September 2015 detailed people’s views. Comments had included: “the carers are very nice and happy and I feel happy with them" and "the care is very good they do as much as they can for us and more". This was echoed throughout our visit from people and their relatives. They told us they felt listened to and felt confident that the manager would act in their best interest should they have a concern or complaint.

The manager was held in high esteem by staff who described her as open, approachable and supportive. They told us that staff morale had greatly improved since the manager’s appointment in July 2015, and that development opportunities had increased to ensure they had the skill and knowledge they needed to meet people’s assessed needs. Comments included: “the manager is excellent with good leadership skills" and "I feel much more informed since she came along, staff spirit and morale has improved”.

A member of the home care team supporting the service with improvements’ stated, “I certainly got the feeling of transparency – a cultural shift that needed to happen". A visiting GP said, “Communications within the home have much improved. Morale has improved and they are a much more cohesive group. Even the care staff talk to you and say hello; they are much more proactive, which I have not seen here before”. A social worker told us they had seen a marked difference in the service over the course of three visits since July 2015, adding: “I do feel she (the manager) has made a difference; people have confidence in the manager”.

Policies and many procedures were electronically held. This made accessibility for staff difficult particularly outside of normal office hours. We were told that managers were available at all times and could provide support to staff, including visiting the home if necessary. There were plans to ensure that a file containing hard copies of all policies was available to staff at all times. A “policy of the week” initiative had been introduced which was designed to ensure that staff knew what particular policies contained and how they related to their everyday practice. We saw documentation which indicated that Duty of Candour, Deprivation of Liberty Safeguards, whistleblowing, uniform and the Mental Capacity Act had been explored with all nursing and care staff since the initiative had been introduced.

We were provided with an environmental check list which was conducted by the manager. This documentation covered areas such as general cleanliness and tidiness in all areas, appropriateness of dining room preparation, state of furnishings throughout and that procedures for the kitchen, laundry and treatment room had been followed. An audit tool for monitoring and driving improvement in the quality of the dining experience had been introduced. Areas which required action were identified with clear directions for staff and when additional resources such as table cloths needed to be purchased.

People’s care plans and other records were being audited and improved at a realistic pace for all staff to fully comprehend and put in to practice. This was with support from the clinical facilitator, home manager and home care support team. People’s records were being regularly scrutinised to promote improvements and ensure peoples’ well-being and safety.

The maintenance person undertook general health and safety checks to ensure that servicing of equipment were up to date. This audit also covered areas such as the call bell system, portable electrical appliances and hazardous substances. We saw records which confirmed that monthly checks of mattresses, pressure mattresses and cushions were undertaken to identify when damage had occurred or replacement was indicated.

Medication audits were completed by an external pharmacist and actions taken by the service to promote the safety of administering people's medicine. Health and safety audits were completed by the service that included infection control and also by external professionals such as the Fire Authority to ensure the safety of the premises for people who use the service.