Care Quality Commission

Barchester Healthcare Homes Limited

Woodside House

Inspection report

Woodside Road
Norwich
Norfolk
NR7 9XJ

Tel: 01603702002
Website: www.barchester.com

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15 June 2017

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 12 and 15 June 2017 and was unannounced. Woodside House is a nursing home that can accommodate up to 56 people. At the time of this inspection 55 people were living in the home, all of whom required nursing care. The home is on one level with 31 beds dedicated to support people living with dementia. This area of the home is called Memory Lane. The remainder of the home comprised of Willow Lane and Sycamore Lane. Some people living in these areas may also be living with dementia.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager in post told us that they were applying to register with us. They had previously been the deputy manager in the home and we have referred to them as the manager throughout this report.

Our previous inspection in September 2016 had identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to safe care and treatment and the management arrangements of the home. This June 2017 inspection found that improvements had been made and consequently the provider was no longer in breach of these regulations.

The service was staffed in accordance with the provider's staffing assessment tool. Feedback we received indicated that this may not have always been sufficient, particularly in relation to the amount of engagement staff were able to have with people. We have recommended that the provider review their staffing and staff deployment arrangements from the day to day perspective of people using the service.

Risks to people's welfare were identified, planned for and mitigated as far as was possible. Suitable staff recruitment arrangements were in place. People received their medicines as prescribed for them. Staff understood their obligations to help keep people safe and to report any concerns that might arise so that suitable action could be taken.

Staff received suitable training and support to help ensure that people's needs were met effectively. People enjoyed the food and where people required specialist diets or assistance to eat their meals, this was received. The provider needed to ensure that people always had drinks available to them. Some people had raised this as an issue with us. The service acted in accordance with the requirements of the Mental Capacity Act 2005 and staff knew about their responsibility to support people to make their own decisions as far as possible.

The staff were caring, warm and promoted people's dignity. People and their relatives were consulted in relation to the care that was planned and their views were acted upon.

The service responded to people's needs. People's care plans were detailed and person-centred.

The service was well managed and robust arrangements were in place to assess and monitor the quality of the service provision.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not consistently safe. Whilst the service was staffed in accordance with the provider's staffing assessment tool, people's physical and social needs were not always met. People received their medicines when they needed them and medicines management arrangements in place were safe. Risks to people's welfare were identified and acted upon to help keep people safe.	**Requires Improvement**
Is the service effective? The service was effective. Staff received appropriate training and support to meet people's needs. The service was working within the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People were offered choices about what to eat and drink.	**Good**
Is the service caring? The service was caring. Staff provided assistance and support to people in a warm and caring manner. People, and their relatives where appropriate, were involved in making decisions about the care that they or their family members received.	**Good**
Is the service responsive? The service was responsive. People care plans contained comprehensive information about	**Good**

how people's needs were to be met.

People and their representatives were confident that if they needed to make a complaint it would be dealt with appropriately.

Is the service well-led?

Good

The service was well led.

There were a range of audits and checks to monitor the quality of the service that people received.

People and their relatives were positive about the management of the home.

Care Quality Commission

Woodside 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 checked 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 12 and 15 June 2017 and was unannounced. The inspection team consisted of three inspectors, one of whom specialised in pharmacy, an expert by experience and a specialist adviser. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of service. The specialist adviser was a registered nurse.

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.

Prior to this inspection we liaised with the local authority and the clinical commissioning group and we reviewed information held about the service. This included statutory notifications we had received from the service. Providers are required to notify us about events and incidents that occur in the home including deaths, serious injuries sustained and safeguarding matters.

During this inspection we spoke with five people living in the home and relatives of seven people. We also spoke with four care staff members, two nurses, the manager and the regional director.

We made general observations of the care and support people received at the service. We looked at the medication records of eight people living in the home and care records for six people. We viewed records relating to staff recruitment as well as training and supervision records. We also reviewed a range of maintenance records and documentation monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Our previous inspection in September 2016 identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach related to concerns we had found in relation to the risks of choking for several people. Safe arrangements had not been made to ensure that drink thickeners were used when needed. Additionally, we had identified concerns about storage arrangements for prescribed creams. Some prescribed creams had been used beyond their expiry date. Some toiletries that could be hazardous to people's health if misused had not been secured.

Due to the serious nature of these concerns, we raised them with the provider at the time of the inspection in September 2016. The provider took urgent remedial actions to address these issues and ensure people's safety at the time. This June 2017 inspection found that people remained protected from these risks. Consequently, the provider is no longer in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed reviews about whether there enough staff available to support people. Most concerns were raised in relation to Memory Lane, the home's dementia care unit.

We observed periods of time in the main lounge in Memory Lane where despite up to ten people being there, no staff were present. A relative of one person told us of a recent occasion when they had had to step in to prevent one person giving another person a drink that was not theirs. This person required their drinks to be thickened to prevent the risk of them choking. The relative told us that they regularly had to find staff to assist people requiring support in this lounge.

Staff told us that staffing levels on Willow and Sycamore Lane were usually adequate and enabled them to meet people's physical needs. However, they were less positive in relation to the staffing of Memory Lane. One staff member told us that they were usually able to manage with five or six care staff and a nurse during the day. However, there were three people who did not receive dedicated support that, if they were having an unsettled day, could take up a lot of staff time which impacted upon their availability to assist other people. A second staff member felt that people were not able to get up when they wished on a Sunday as those who attended religious services received priority.

Just before lunch on Memory Lane we heard three staff discussing that they had been too busy to take their breaks that morning. We saw staff on two occasions having trouble locating other staff to assist them to move people to take them to the bathroom. This had resulted in people becoming distressed. During lunch we observed that one person waited 40 minutes in the main dining room before being assisted to eat their lunch.

One person asked, "Why isn't there a bell in the atrium? There's not always someone there all the time so what happens if we need help?" Another person said, "Sometimes the bells ring for five to ten minutes." Several people told us that staff were busy and did not have enough time to speak with them, other than when providing direct assistance. One said "Generally, I'm the one who starts a conversation as they are too

busy to stop." Another said, "It's difficult for staff because they are so busy. You are the first person who has asked me about myself and my life." Another person told us, "They ask me if I'm okay but it's more about that than a meaningful chat with me."

We saw from staff rotas that the service was usually able to provide staffing levels in accordance with the provider's staffing assessment tool. We were also told that in response to recent concerns raised by the Clinical Commissioning Group about staffing levels during the evening on Memory Lane that the service would be introducing a twilight shift from the week after our inspection.

We recommend that the provider re-evaluates staffing levels and staff deployment arrangements from the perspective of people using the service to ensure there are sufficient and consistent numbers of staff available, to safely meet the physical and social needs of people living in the home.

Some people and their relatives told us that they had no concerns about staffing levels. One person said, "I don't have to wait if I need help." One relative told us, "I've never considered that they are short of staff." Another relative stated, "Staffing numbers seems okay to me."

Appropriate steps were taken to minimise the risks of employing staff unsuitable for their role. We reviewed staff recruitment records for three recently recruited staff. References were obtained and checks were carried out with the Disclosure and Barring Service (DBS) to ensure that prospective staff were not barred from working in the care sector nor had criminal records that would prohibit their employment. Checks were also made to ensure that the professional registration required for nursing staff was in date.

Risk assessments and plans were in place to identify whether people were at risk and details of the actions staff needed to take to mitigate risks to people's welfare were recorded. Records we reviewed covered areas such as medicines, nutrition, falls, continence support, mobility and pressure area care. Risk assessments and action plans were personalised to cover each person's individual requirements. They detailed what equipment and staff support was required whilst taking into account people's preferences. For example, one person at high risk of falls preferred not to wear footwear but staff had ensured that the socks they wore had silicone dots on the soles to help with grip.

A member of our medicines team looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines.

Staff authorised to handle and give people their medicines had received training and had been assessed as competent to undertake medicine-related tasks. We observed part of the morning medicine round and saw staff following safe procedures when giving people their medicines.

Medicines were being stored safely for the protection of people who used the service and at the correct temperatures. Records showed that people were receiving their medicines as prescribed. There were regular internal audits in place to enable staff to monitor records and account for medicines. Issues arising were promptly identified and raised as incidents to be resolved. Learning from these was then directed to staff.

We noted supporting information was available to enable staff handling and giving people their medicines to do so safely and consistently. There was personal identification and information about known allergies/medicine sensitivities and written information on people's preferences about having their medicines given to them.

For people prescribed medicated skin-patches, additional charts were in place to record the application of

the skin patches, but records of the removal of previous patches were not always being completed to ensure safety. When people were prescribed medicines on a when required basis, there was written information available to show staff how and when to give people these medicines, however, we advised the manager more detail was needed for some medicines prescribed in this way.

For people with limited mental capacity to make decisions about their own care or treatment there were records of best interest decisions to give people their medicines crushed in food or drink (covertly). This followed assessments of their mental capacity and consultation with their GPs, pharmacists and relatives or advocates about this.

Staff we spoke with had a good understanding about keeping people safe. One staff member told us how they had reported a concern they had to the manager and it had been dealt with effectively. Staff understood the range of concerns that could necessitate a safeguarding concern and what external organisations they could report concerns to if they felt this was needed. We found that the service had made appropriate safeguarding referrals when necessary.

Good

Is the service effective?

Our findings

People were confident that staff had the skills to support them effectively. One person stated, "The carers know what they are doing which is re-assuring." Another person told us, "They move those with mobility difficulties really well and very carefully." A third person said, "The staff are competent in every way."

Staff received suitable training and support to help them meet people's needs safely and effectively. A high percentage of staff, over 96%, were up to date with all the statutory training required by the provider. This included moving and handling, infection control, safeguarding and the Mental Capacity Act 2005. One staff member told us that their training was, "…. first class and mainly face to face."

Nursing staff had received up to date training in cardio pulmonary resuscitation, venepuncture, catheterisation, diabetes management, tissue viability and the use of syringe drivers. The service followed an accredited end of life framework for those living with life limiting conditions.

Staff told us that they were supported by senior staff and managers and that they received supervisions on a regular basis. They also told us that there was always someone available to discuss any concerns they had about how best to care for people. The manager was observed offering to help out staff if they needed it. One staff member told us, "[The manager] will always help out if needed."

We observed lunchtime in three areas of the home. Tables were attractively laid with table cloths and napkins and people were offered a choice of drinks. People were shown the main options available at the table so they could choose. If they did not want either of the options available, they were offered alternatives. Those that required assistance to eat their meals received this. However, one person had needed to wait for 40 minutes for a staff member to become available to support them.

Staff had a good knowledge of people's food and drink requirements. Several people living in the home followed specialist diets, including pureed, high calorie and diabetic diets. Constituent parts of meals were blended separately for people who required their food to be pureed. This meant that there was a range of food colours on a plate which helped to make these meals as appetising as possible. Some people required their drinks to be thickened to reduce the risk of choking and staff ensured that this was done. Fresh fruit and snacks were freely available.

Our inspection took place during a period of hot weather. We saw that people had drinks available to them most of the time. Staff were regularly replacing or topping up people's drinks. We saw that when some people were assisted to eat their meals staff did not regularly offer a drink in between several mouthfuls. A few people raised concerns about the availability of drinks. One relative said, "I think it would be a good idea if they had drinks by their side. I've noticed that they often don't." Another told us, "[Relative] doesn't always have a drink on the table next to them." One person said, "I get a bit thirsty sometimes because you need to ask for a drink of water in the lounge."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 and found that it was.

We found that mental capacity assessments had been carried out to determine people's ability to make specific decisions. We saw that where appropriate that people's relatives had been involved in the process and in determining decisions made in people's best interests. Where people were deprived of their liberty in order to keep them safe relevant DoLS applications for this had been submitted to the local authority.

Throughout our inspection we saw that people were encouraged to make decisions about their care and their day to day routines and preferences.

Records showed that people were being supported by a wide range of health and social care professionals including dieticians, speech and language therapists, mental health practitioners, the falls prevention team and chiropodists. One person told us, "If I want a doctor, I know they'll call one for me."

Good

Is the service caring?

Our findings

People living in the home were mainly positive about the staff that supported them. One person told us, "One is not so nice but the rest are very kind." Another person said, "The staff are friendly and willing to help." A third person stated, "The staff are decent people and very caring." One person said, "I feel that they see me as a friend because they speak to me nicely."

However, the same people also felt that staff were often too busy to chat with them more generally. One person said, "Sometimes I feel a part of the furniture. It would cheer me up if there was a better relationship." Another said, "It would make me happier if we spoke to each other more." A third person said, "If they had time to speak with us, it would make more of a bond between us and the carers."

People's relatives were also complimentary. One told us, "The staff are so gentle and caring in what they do and say. They know that [relative] is not receptive but they talk to them even though they get no response." Another relative said, "They are respectful and welcoming to everyone."

We reviewed letters received by the home from people and their relatives thanking staff for the care they had provided. One relative thanked a named staff member who had accompanied their family member to a hospital visit when they had not been scheduled to work. Another acknowledged the assistance of the housekeeping team with labelling their family member's clothes, affectionately referring to them as the 'pink ladies' due to the colour of their uniform.

We saw that staff interactions with people were relaxed, friendly and respectful. Staff assisting people to do activities enthusiastically engaged with people about what they were doing which elicited smiles and conversations. When staff were transferring people with hoisting equipment they were attentive and patient, explaining clearly what was happening. One person who had been contentedly looking after a doll was hesitant to leave it to have their lunch. A staff member empathetically offered to look after the person's doll explaining that this would give the person a break whilst they had their lunch.

People's privacy and dignity was usually upheld. People's doors were shut when personal care was being provided. We observed staff supporting people discreetly to the bathroom. However, we did note that during lunch one staff member wiped a person's face with their clothes protector rather than a napkin.

People we spoke with told us that they were involved in the planning of the support they required. Relatives also told us that they had a good dialogue with staff regarding their family member's care arrangements. One relative told us, "My [family member] had a pressure sore when they were admitted to the home. Staff talked me through the strategies they wished to put in place to heal it."

We saw care plan reviews which showed that people and their relatives had participated in discussions about the care that was required. These detailed people's preferences about how they wished to be supported. For example, one person wished to have a commode and urine bottle available for them in their room. Another person's records showed that they only wished to be re-positioned in bed in a certain way.

We found that both requests were adhered to.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs. One relative told us that when their family member developed an infection that it was dealt with very quickly and their relative recovered promptly. Another relative told us, "They sort things out. When [family member's] top was wet, they responded straight away and changed it." A third relative said, "I moved [family member] from another home because they and I were unhappy. They've got [family member] walking again and off the catheter. They are happy and settled here." One person told us that when their lightbulb went, it was quickly replaced.

We observed that one person had soiled their clothes. When we next saw them 20 minutes later they had been assisted to wash and change.

The manager took on board people's comments. A relative had raised an issue about people not receiving afternoon tea until 4pm. This was mainly due to the amount of time it took staff to make hot drinks in the individual kitchenettes in the home and take it to people. On Memory Lane the kitchenettes were at either end of a long corridor. The previous manager had preferred not to use a tea trolley because it could be considered as an institutional practice. However, the new manager had taken a more pragmatic view. A tea trolley had been re-introduced at an earlier time. This meant that there was less of a gap between meals for the provision of snacks and hot drinks. People were pleased with this change. One person said, "This arrangement is much better."

We also saw that resident and relative meetings were held at weekends as well as during the week. This followed a request made to help enable relatives to attend who might have found it difficult during the working week.

People's care records held a good standard of detail about the care and support that people needed. Prior to moving in to the home people's needs were assessed to ensure that the home would be able to provide the level and type of support that they required. Once people had moved in to the home their care plans had been developed promptly.

Staff were clear that they were guided by people's individual wishes and accommodated them wherever possible. One staff member told us, "We want to provide the right care at the right time rather than following a routine." Staff members we spoke with demonstrated a comprehensive knowledge of the people they were supporting. For example, one staff member told us how one person's mobility could vary from day to day and that they assessed the type of support the person required on an ongoing basis. They said, "We judge when to use the hoist with [the person] as it varies from day to day. Sometimes they can't weight bear, but other days they can and we don't want to take away what independence they have. We're very careful with this."

People we spoke with and their relatives were satisfied with the range of activities that were on offer. Schedules were available throughout the home giving details of what events were happening and when and where they would be taking place. Some people preferred to spend their time in their rooms, chatting with

others or watching rather than participating in events happening in the home.

Some people told us that they enjoyed spending time in the garden. One said, "The gardens are lovely and we're doing some great work. We are creating a beach area with painted beach huts, boats and a blue area for the sea."

A relative told us that staff knew what hobbies and interests their family member as this had been discussed in detail when the person moved in to the home. They told us how sometimes they did some painting together. They were very positive about the activities staff members and said that they arranged interesting things for people to do.

People and their relatives told us they would not have any reservations about making a complaint if they felt this was necessary. The felt that any concerns raised would be taken seriously and dealt with appropriately. One person told us, "I would have no problem speaking to someone senior if I wasn't happy." A relative told us, "I would confidently go to the manager if there were an issue to sort." A second relative told us that when they had made a complaint the issue was rectified promptly and an apology had been received.

Good

Is the service well-led?

Our findings

Our previous inspection in September 2016 identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach related to the governance arrangements in the service which had failed to identify the concerns we had found at this September 2016 inspection.

This June 2017 inspection found that improvements had been made and that the systems in place to ensure people received a good standard of care had improved considerably. Consequently, the provider is no longer in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was no longer working at the home. The acting manager, who had previously been the deputy manager, had taken over the manager's role in May 2017. They told us that they were in the process of applying for registration with CQC.

During this inspection we reviewed a range of audits and checks that were regularly carried out. The provider had a rolling programme of monthly audits that covered areas such as medications, care documentation, infection control and nutrition and hydration. These were comprehensive and up to date. The monthly audits were supplemented by a weekly check in relation to medicines management and administration. These checks reviewed the arrangements in place for a sample of people's medicines. We also saw that there were good managerial oversight arrangements for a range of areas including falls, tissue viability and nutritional risks.

The manager received support from the regional director who was present during the inspection. Having read some correspondence we were concerned about the amount of pressure put on the manager to work within the provider's staffing assessment calculation. The regional director advised us that when necessary, there was the flexibility to amend staffing levels outside of the staffing assessment calculation. For example, it had recently been decided to implement a twilight shift on Memory Lane following concerns raised by health professionals that there were not sufficient staff available to meet people's needs in the evenings.

A good system of hand over meetings was in place to facilitate communications between managers, nurses and staff. Nursing staff had a meeting with the manager each morning so that all parties were aware of specific issues that may require their involvement. Nursing staff did a hand over to the next nurse on duty who in turn briefed staff on their shift. We saw that staff meetings were held on a regular basis. Staff that were not present were required to read the minutes from meetings so that they were aware of items discussed and any decisions made.

People, their relatives and staff were positive about the way the home was run. The new manager had introduced themselves and advised of other staff changes in the home in a specially held meeting for people and their relatives. We saw minutes which detailed the plans the manager had for the home, particularly in relation to activities. People and their relatives were encouraged to ask questions and raise any issues they might have.

One person told us, "The place is well run. I'd be happy for a relative to join me here." A relative said, "The management has to take credit for a great deal. The caring is excellent." Another relative said, "I'd recommend the place to others." A third relative told us, "I've visited other homes and this is the best based on things like the atmosphere and level of activities."

Staff were positive about the appointment of the new manager. One staff member told us, "Staff morale is much better." Another said, "The atmosphere is better and morale is sky high."