Qualia Care Limited

Washington Lodge

Inspection report

The Avenue
Washington
Tyne And Wear
NE38 7LE

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08 January 2018
10 January 2018

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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 8 and 10 January 2018 and was unannounced. This meant the staff and provider did not know we would be visiting.

Washington Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Washington Lodge accommodates up to 65 older people in one adapted building across two floors. Some of the people were receiving nursing care and some were living with a dementia type illness. On the days of our inspection, there were 39 people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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.

Washington Lodge had not previously been inspected by CQC under the current provider.

Accidents and incidents were appropriately recorded and investigated, and risk assessments were in place for people who used the service that described potential risks and the safeguards in place to mitigate these risks. The registered manager understood their responsibilities with regard to safeguarding and staff had been trained in safeguarding vulnerable adults.

Medicines were stored safely and securely, and procedures were in place to ensure people received medicines as prescribed.

The home was clean, spacious and suitable for the people who used the service and appropriate health and safety checks had been carried out.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff. Staff were suitably trained and training was arranged for any due refresher training. Staff received regular supervisions and an annual appraisal.

People were supported to have maximum choice and control of their lives, and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of people being supported during visits to and from external health care

specialists.

People who used the service and family members were complimentary about the standard of care at Washington Lodge. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

Support plans were in place that recorded people's plans and wishes for their end of life care.

Care records showed people's needs were assessed before they started using the service and support plans were written in a person-centred way.

Activities were arranged for people who used the service based on their likes and interests and to help meet their social needs. The service had good links with the local community.

People who used the service and family members were aware of how to make a complaint however there had been no formal written complaints recorded at the service.

The provider had an effective quality assurance process in place. Staff said they felt supported by the registered manager and were comfortable raising any concerns. People who used the service, family members and staff were regularly consulted about the quality of the service via meetings and surveys.

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.

Staffing levels were appropriate to meet the needs of people who used the service and the provider had an effective recruitment and selection procedure in place.

Accidents and incidents were appropriately recorded and investigated, appropriate risk assessments were in place and staff had been trained in how to protect vulnerable adults.

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

Is the service effective?

Good

The service was effective.

Staff were suitably trained and received regular supervisions and appraisals.

People's needs were assessed before they began using the service. People had access to healthcare services and received ongoing healthcare support.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA).

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and independence was promoted.

People were well presented and staff talked with people in a polite and respectful manner.

People had been involved in writing their care plans and their wishes were taken into consideration.

Is the service responsive?

Good

The service was responsive.

Support plans were written in a person-centred way.

The home had a full programme of activities in place for people who used the service.

The provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The service had a positive culture that was person-centred, open and inclusive.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

The service had good links with the local community.

Washington Lodge

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 8 and 10 January 2018 and was unannounced. This meant the staff and provider did not know we would be visiting. One adult social care inspector and a specialist advisor in nursing took part in this inspection.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. We also contacted Healthwatch. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work. Information provided by these professionals was used to inform the inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with four people who used the service and seven family members. We also spoke with the registered manager, operational support manager and seven members of staff.

We looked at the care records of four people who used the service and observed how people were being cared for. We also looked at the personnel files for four members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

We used the 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 with us.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe at Washington Lodge. One person told us, "It's very safe." Another person told us, "Yes, I feel safe." A family member told us, "Safe? Oh yes."

Staff recruitment records showed that appropriate checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. Application forms were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained.

We discussed staffing levels with the registered manager and looked at staff rotas. The registered manager told us agency nursing staff were used on night shift but they had used the same nurses for the previous six months. They told us recruitment was ongoing to fill the vacancies at the home. A dependency tool was used to calculate staffing levels and we saw these levels were achieved on the rotas we viewed. The operational support manager told us staffing was going to be discussed at the next senior management team as they were proposing increasing the staffing levels at night. People who used the service, family members and staff did not raise any concerns regarding staffing levels and we saw calls for assistance were answered in a timely manner. This meant there were enough staff on duty to meet the needs of the people who used the service.

The provider had a number of infection prevention and control policies and a quarterly infection control audit took place. The home was clean, spacious and suitable for the people who used the service, and no odours were present. Appropriate personal protective equipment (PPE), hand hygiene signs and liquid soap were in place and available. Communal bathrooms and toilets were generally clean and some had been refurbished. However, in one bathroom the seal on the lower part of the wall was coming away from the wall. We discussed this with the registered manager who told us they were aware of it and it was included in the refurbishment plan for the home.

Daily cleaning records were in place and were up to date. These recorded what cleaning had been carried out in each room or area and were signed. A family member told us, "It [the home] really smelled when I first came but it's all been refurbished since then. They've replaced old carpets with flooring. Now it's not a problem."

Accidents and incidents were appropriately recorded and a monthly analysis was carried out to identify any trends. For example, falls were analysed by type, time, person and location to identify any trends. Records included details of action taken to reduce the risk of a recurrence and any lessons learned that were discussed with staff in supervisions and staff meetings. Risk assessments were in place for people who used

the service and described potential risks and the safeguards in place. Risk assessments included falls, bedrails, nutrition and choking. This meant the provider had taken seriously any risks to people and put in place actions to prevent accidents from occurring.

Relevant safety checks and servicing had been carried out to ensure people were safe. These included electrical installation, portable appliance testing (PAT) and water temperatures. Equipment was in place to meet people's needs and where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER).

Risks to people's safety in the event of a fire had been identified and managed, for example, a fire drill took place on the first day of our visit, a fire risk assessment was in place and the fire alarm and firefighting equipment was regularly checked and serviced. The service had an emergency and a contingency plan and Personal Emergency Evacuation Plans (PEEPs) were in place for people who used the service. This meant that checks were carried out to ensure that people who used the service were in a safe environment.

The provider's safeguarding service users from abuse policy defined the different types of abuse, the role of staff in preventing and identifying abuse, and procedures to follow to report and investigate any allegations of abuse. Safeguarding related incidents were appropriately recorded and CQC was notified of any relevant incidents. The registered manager understood their responsibilities with regard to safeguarding, staff we spoke with demonstrated a good understanding of how to protect vulnerable people and had received appropriate training. We found the provider understood safeguarding procedures and had followed them.

Appropriate arrangements were in place for the safe administration and storage of medicines. Medicines were recorded on individual medicine administration records (MAR). Records we viewed were accurate and up to date. A MAR is a document showing the medicines a person has been prescribed and records whether they have been administered or not, and if not, the reasons for non-administration.

Medicines were appropriately stored in secure trolleys in a locked room. Room and refrigerator temperatures were recorded daily to ensure medicines were stored at the correct temperatures. We saw one bottle of prescribed eye drops had been opened on 8 December 2017 and had not been discarded within two weeks of opening as per the instructions. This was brought to the attention of the nurse and acted upon immediately.

Staff were aware of procedures with regard to the storage, administration and disposal of medicines, and relevant guidance was available. Medicines audits were carried out on a monthly basis and where issues had been identified, we saw they had been rectified.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. A family member told us, "[Name] was bed bound when they came in. The staff worked very hard with [name]. [Health professional] came in then and now and can't believe the difference in [name]" and "Everything I've asked them [staff], they've done." Another family member told us, "The staff are excellent."

Staff were supported in their role and received regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace.

The registered manager used a training matrix to monitor staff mandatory training. Mandatory training is training that the provider deems necessary to support people safely and included moving and handling, safeguarding, fire safety, mental capacity, food hygiene and nutrition, infection prevention and control, health and safety, equality and diversity, and dignity in care. Staff also completed role specific training such as tissue viability and challenging behaviour. Where training was due we saw it was planned.

New staff completed an induction to their role and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

People's needs were assessed before they started using the service and continually evaluated in order to develop support plans. The registered manager described the admissions process for one person who had been admitted from hospital. They told us care staff from Washington Lodge had spent a week visiting the person and getting to know their needs before they were admitted into the home.

People were supported with their dietary needs. Food and fluid intake was recorded for people and nutritional assessments were in place. People were referred to relevant healthcare professionals where required, for example, dietitians and speech and language therapists (SALT). People's weights were recorded weekly or monthly depending on their assessed needs and risk assessments were in place for those people identified as being at risk, for example, of choking.

People had access to a choice of food and drink throughout the day and we saw staff supporting people who required assistance in the dining rooms at lunch time. People were supported to eat in their own bedrooms if they preferred. People chose from the menu on the day and alternatives were available. The registered manager showed us a pictorial menu file they were in the process of developing to assist people with dementia and communication needs.

A family member told us their relative was on a soft diet when they moved into the home and had lost a lot of weight. They told us the person was now on a normal diet and was back to a healthy weight. They told us, "[Name] has come on leaps and bounds since they came in here. [Name] eats things they've never eaten in their life. [Name] now eats anything!" Another family member told us, "The food is excellent, I can't fault it."

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 and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had submitted DoLS applications to the supervisory body where appropriate and had notified CQC of any authorisations. Mental capacity assessments and best interest decisions had been made and recorded, and were decision specific.

Some people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in place, which means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). Records we viewed were up to date and showed the person who used the service and their family had been involved in the decision making process.

People who used the service had access to healthcare services and received ongoing healthcare support. This included visits to and from external specialists such as GPs, community nurses, dietitians, SALT, chiropodists and opticians.

Some of the people who used the service were living with dementia. The home had incorporated some environmental aspects that were dementia friendly. For example, corridors were well lit, handrails contrasted with the walls and communal bathroom and toilet doors were clearly signed. People's bedroom doors included the room number, a door knocker, the person's name and photographs of the person's choice. There was little visual stimulation on corridor walls. We discussed this with the registered manager who told us they were aware of this, it was work in progress and was included in the refurbishment plans.

Good

Is the service caring?

Our findings

People who used the service and family members were complimentary about the standard of care at Washington Lodge. They told us, "It's wonderful, so caring", "I can't fault the care here" and "I cannot fault the care [name] is receiving."

People we saw were well presented and looked comfortable in the presence of staff. We saw staff speaking with people in a polite and respectful manner and staff interacted with people at every opportunity. We saw and heard how people had a good rapport with staff. For example we heard a staff member say, "Good morning, are you alright darling?" The person smiled. We observed staff laughing, joking and holding hands with people. People were smiling and obviously enjoying the interactions.

We saw staff knocking before entering people's rooms and closing bedroom doors before delivering personal care. Care records described how staff were to respect people's privacy and dignity. For example, "Staff should encourage privacy and dignity by having carers be female if possible." We observed a staff member discreetly ask a person if they needed to go to the toilet and assisted them quietly out of the room. Our observations confirmed staff treated people with dignity and respect and care records demonstrated the provider promoted dignified and respectful care practices to staff.

Staff supported people to be independent and people were encouraged to care for themselves where possible. Care records described what people could do for themselves and what they needed support with. For example, "[Name] needs support and assistance to maintain oral hygiene", "[Name] is able to mobilise short distances with the support of one care staff" and "[Name] needs full support with their personal care." One person's care record clearly described what they could do for themselves. For example, positional changes in bed, sitting up and repositioning. However, they required support from one member of staff with bathing, washing, toileting and mobilising.

People's preferences were clearly documented in their care records. For example, one person wanted support to attend the hairdresser whenever they wished. People's religious and spiritual needs were respected and catered for. Church services were held regularly at the home and weekly visits took place to the local church.

People had communication support plans that described people's communication abilities, how they preferred to communicate and what support they required from staff. For example, one person's record stated, "[Name]'s speech is clear but at times they are unable to have a full conversation" and "Staff to promote and maintain effective communication, can use closed, simple questions."

We saw that records were kept securely and could be located when needed. This meant only care and management staff had access to them, ensuring the confidentiality of people's personal information as it could only be viewed by those who were authorised to look at records.

Advocacy services help people to access information and services, be involved in decisions about their lives,

explore choices and options and promote their rights and responsibilities. We saw a copy of the provider's advocacy policy and discussed it with the registered manager. They told us three of the people using the service had independent advocates.

Good

Is the service responsive?

Our findings

Care records we looked at were regularly reviewed and evaluated. A staff member told us all care records were evaluated on a monthly basis but more often if there was a need.

The records were person centred, which means the person was at the centre of any care or support plans and their individual wishes, needs and choices were taken into account. Records included 'This is me' documents that contained important information about the person including their likes and dislikes. We saw records had been written in consultation with the person who used the service and their family members.

Support plans were in place that recorded people's individual needs in that area and what support they required from staff. For example, moving and handling support plans detailed the type of movement to take place, how many staff were to be involved and any equipment that was to be used to ensure the safe moving and handling of people. Appropriate risk assessments were in place where required.

Daily records were kept for each person and included an update on their general health, diet, medicines, activities, professional visits and sleep pattern.

End of life support plans were in place for people as appropriate and documented people's wishes. For example, in one person's support plan it stated they did not want to implement an end of life support plan unless there was a marked deterioration in their health. Another person's support plan stated they did not wish to have one in place. Staff we spoke with demonstrated good knowledge of end of life care. One staff member told us, "No resident dies alone."

We found the provider protected people from social isolation. A variety of activities were available at the home based on people's individual wishes and needs. Visitors to the home included singers, entertainers and choirs. People were supported to attend a coffee morning every week at the local church. We spoke with one of the activities coordinators who told us about their plans for future activities. They told us they were fully supported in their role and, "If I need something, I can have it."

We saw a party was being held to celebrate the one year anniversary of the home being taken over by the provider. People, family members, visitors and staff played games and enjoyed cakes. A person who used the service told us, "There's always something going on." Another person told us, "It's lots of fun." A family member told us, "They do arts and crafts, painting, all sorts. The activities coordinator is wonderful."

The provider's complaints policy was on display in the foyer and a copy was in the service user guide. This described the complaints process and how long it would take for a complaint to be acknowledged and investigated. There had not been any formal written complaints recorded at the service in the previous 12 months but there had been three verbal complaints, all of which had been actioned appropriately. The registered manager maintained a log so they could monitor complaints and compliments and ensure appropriate actions had been carried out. A family member told us, "If I've got a gripe, I tell them. If I ask

them to do something, they do it. No complaints."

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. They had been registered with CQC since January 2017. We spoke with the registered manager about what was good about their service and any improvements they intended to make in the next 12 months.

The registered manager told us a member of staff was going to attend a dementia 'train the trainer' course so they could disseminate the training to the other staff. They had identified other sources for training through the local clinical commissioning group (CCG) and other local organisations. This included end of life, infection control and reducing hospital admissions. They also told us they worked closely with the community nursing teams and had developed food and fluid charts that were now used in other homes, and the community nursing teams received copies of monthly charts so they could proactively monitor them.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.

The service had good links with the local community. This included the local primary school, the action on dementia group, the local church, the village pub and the local historical society who were attending the home in the near future with photographic displays.

Staff we spoke with felt supported by the registered manager and told us they were comfortable raising any concerns. Staff comments included, "It's a lovely little home", "We get lots of support", "I'm very happy here" and "They [registered manager] are very supportive." Staff were regularly consulted and kept up to date with information about the home and the provider via staff meetings and an annual staff survey. The results of which were analysed and fed back to staff.

We looked at what the provider did to check the quality of the service, and to seek people's views about it. The provider carried out a quarterly audit of the service based on the CQC five key questions. This included an audit of care records, staff files, staff morale, safety, equipment, training and supervisions, and quality of care. Any areas for improvement were recorded in the action plan. In addition, a monthly home review was carried out that included catering, laundry, maintenance and the environment.

The registered manager had an audit calendar. This included audits on the laundry, medication, kitchen, infection control, hand hygiene, care files, and beds, mattresses and bed rails. Records we viewed were up to date. The registered manager also produced a weekly report for the provider on occupancy, any safeguarding related incidents, accidents, complaints, recruitment and vacancies, sickness, agency use, training, health and safety, and any additional comments.

Monthly residents' and relatives' meetings took place. People and family members were given the opportunity to comment on the premises, activities, meals and any other subject they wished to raise. We

saw the results of the annual relatives' survey that had taken place in December 2017. 33 surveys had been sent out and 10 had been completed. The service scored 100% in several categories including cleanliness, staff training and competency, visitors feeling involved and consulted, and manager and staff availability.

This demonstrated that the provider gathered information about the quality of their service from a variety of sources and acted to address shortfalls where they were identified.