Life Style Care (2011) plc

Windmill Care Centre

Inspection report

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Ratings

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

Overall summary

Overall summary We carried out this unannounced inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This unannounced inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service.

Windmill Care Centre provides accommodation and nursing care for up to 53 older people over three floors. The first floor can accommodate up to 23 people who live with dementia. At the time of our visit there were 40 people living at the service.

There was a registered manager in post. A registered manager is a person who has registered with CQC to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

We spoke with 13 people who were living at Windmill Care Centre, 5 relatives, 14 members of the nursing and care staff team and with the manager of the home. We also spoke with two senior managers for the provider and with a GP.

People who lived in Windmill Care Centre and their relatives told us they were very satisfied with the care they received or observed. They said staff were caring and competent and communication between themselves and staff was good. They told us they were involved with their care, treated with respect and their dignity was protected.

People could be at risk from equipment which had not been maintained appropriately as routine maintenance had not consistently been carried out on fire alarms and smoke detectors and the provider had not always recorded when equipment had been tested.

Health and social care professionals involved with Windmill Care Centre and the people who lived there, told us there had recently been significant improvements in the standard of pressure care and associated care records. However we found in some cases further improvement was required to ensure care records were consistently well-completed.

Some care records were incomplete. For example, some people's weight had not been recorded monthly and staff had not consistently recorded if they had assessed a person's pain or their risk of depression. Care records could not always be relied upon to accurately reflect people's care needs or the care provided.

People were offered choice and given the time to make decisions, for example about what they ate or if they wanted to participate in activities.

The service's recruitment process included checks which protected people from the employment of unsuitable people.

Staff at all levels had a good understanding of the care needs of people and how these were to be met. Where people did not have capacity to make certain decisions about their care, there was a robust process in place and being followed to ensure that any decisions being made on their behalf were in their best interests.

Staff were supported through training and supervision. They knew how to identify signs of abuse and how to report it. Staff training was being monitored so updates could be identified and planned for. People could be confident their care was provided by staff who had received up to date training.

There was very positive interaction between staff and people they cared for. People told us they would like more activities outside of the home. This was being actively addressed; however there had been some disruption to the choice of activities due to staff sickness. We saw activity sessions took place on both days of our visit. One to one sessions were also programmed for individuals who might not be able or choose to access activities within the home.

Quality assurance and monitoring systems were in place. These had identified areas that needed improvement, including care and maintenance records. An action plan with expected completion dates was in place. This showed where improvement were required this had been identified by the provider and action was planned to improve the service for people.

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?

Requires Improvement

The service was not safe. Maintenance had not consistently been carried out on fire alarms and smoke detectors and the provider had not always recorded when equipment had been tested. This meant people could be at risk from equipment which had not been maintained appropriately.

Staff had been trained to recognise potential or actual abuse and knew what to do if it were seen or suspected. We found that mental capacity assessments and best interest meetings had taken place as required under the Mental Capacity Act (2005) and the service was meeting the requirements of the Deprivation of Liberty Safeguards.

Risk assessments were carried out to make sure people were protected from harm. Risks to their health, safety and welfare had been identified and action taken to eliminate or manage them.

Is the service effective?

Requires Improvement

The service was not effective. Care records were not consistently fully completed and did not always accurately reflect the care provided.

People were well cared-for. Relatives were very positive about the standard of care and support they observed. People had access to community health services, for example, GPs, dentists and opticians.

Staff received the training they needed to provide effective care.

Is the service caring?

Good

The service was caring. People were well-cared for and were very positive about the staff and how they supported them.

There were positive interactions between staff and people they cared for.

People were supported to be involved and make decisions about how their care was provided.

Is the service responsive?

Good

The service was responsive. People were encouraged to remain as independent as possible. Care plans detailed people's needs and their preferred manner of support.

People who received care and their relatives were asked for their views on the care provided and were involved in routine reviews of care.

Staff responded promptly and positively to people as they provided care and support for them. Call bells were answered promptly.

Summary of findings

Is the service well-led?

Good

The service was well-led. The manager and their team were approachable and available when people needed to talk with them.

The manager had been supported by the provider to improve the standard of care and care records Additional management resources had been put in place. A deputy manager was now in post. The registered manager had received regular support from senior managers and was also being supported through the input of another registered manager

Staff felt well-supported by the manager. Systems to monitor staff training and supervision were in place to ensure people received care from staff with the skills and support they required to do so effectively and appropriately.

Windmill Care Centre

Detailed findings

Background to this inspection

We visited Windmill Care Centre on the 15 and 16 July 2014. The inspection team consisted of an inspector and on the first day only, an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case they had experience of services for older people, including people living with dementia.We last inspected Windmill Care Centre on the 14 November 2013 and found no concerns which required action by the provider.

We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR was information given to us by the provider. This enabled us to ensure we were addressing potential areas of concern. We also asked health and social care professionals, for example, G.Ps and commissioners, for information to support the inspection process. We received information from four G.Ps and the local authority commissioners. We also reviewed notifications sent to us by the Provider. Notifications are information about important events the service is required to send to us by law.

Between October 2013 and May 2014 the local authority had placed a temporary restriction on admissions to the first floor of the service. This was because they had been made aware of concerns about how care was monitored and recorded and the care of people's skin. Between December 2013 and May 2014 similar concerns also arose from safeguarding alerts made to the local authority. Following this visit we were informed the restriction on admissions had been lifted as improvements in care and records had been achieved by the service.

We spoke with 13 people who were living at Windmill Care Centre, 5 relatives of people who lived there, 14 members of the nursing and care staff team and with the manager of the home. We also spoke with two senior managers for Lifestyle Care (2011) plc and with a GP.

We observed people in different areas of the service, for example lounges and dining areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also looked at records including six people's care plans, staff training and those relating to the management of the service.

Is the service safe?

Our findings

There were maintenance schedules for equipment which required regular testing to make sure it was safe. Maintenance and servicing records for assisted bathing equipment showed this was regularly checked to make sure it remained safe and effective. However, an audit carried out by a senior manager on the 11 July 2014 identified fire alarm/smoke detector certificates, boiler service report, lift test certificate and firefighting equipment certificate were out of date or records had not been completed. This meant people were at risk from equipment which had not been maintained appropriately.

A maintenance officer had recently been appointed to ensure improvements in record keeping took place.

The service was clean and tidy and staff had appropriate training in infection control. People were usually protected from the risk of infection as most staff wore protective clothing. However, when we observed breakfast on the first floor one staff member did not wear protective clothing when supporting a person. Some crockery laid out for people to use was chipped or stained which could also present a risk of infection.

People who had reduced mobility could be safely supported to use toilets and bathrooms as equipment, for example, hoists were available.

Although people did not always use the word 'safe' , they did tell us they were well-cared for, their needs were met and the staff were kind. "Carers help me with everything, pills and all. I trust them", "Kindness itself" and "Very happy, everything is good, food, carers and nurses." were three people's comments.

People's care plans included detailed assessments about potential risks to their health and safety. There was information about how identified risks could be eliminated or managed. Records of people's falls were examined to identify trends, for example when and where they occurred. The number of staff needed to help people with their care and moving around the service had been assessed. These assessments of risks had been reviewed and updated where necessary. This helped keep people safe if risks changed over time. The PIR included a commitment to positive risk taking 'to ensure residents' liberty and risk are balanced'.

Bedrails had been provided for a person who had suffered a fall. Their care plan included a revised risk assessment and a mental capacity and best interest assessment which. had been undertaken. This process had included the person's family. This showed people received effective care, based upon their current needs assessment, which was reviewed to ensure it remained effective.

Between October 2013 and May 2014 reviews by health and social care professionals had found pressure relieving equipment, for example, mattresses, had not always been set correctly in line with the requirements of people's care plans. This meant people had been at increased risk of skin tissue damage. We checked six pressure mattresses against the settings recommended in people's care plans and found they were all set correctly. We were also told by the local authority they had recently checked pressure mattresses and found they were correctly set.

Care plans included assessments of people's capacity to make decisions for themselves. Where it was assessed they could not safely do this, a process was in place which ensured decisions made on their behalf were in their best interest and lawful.

Training records showed all staff had completed Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DOLS) training. (These are important pieces of legislation which establish people's right to take decisions over their own lives whenever possible and to be included in such decisions at all times. They also establish people's right not to have their liberty restrained where there is a less restrictive way of protecting their best interests and safety.) At the time of our inspection we were told four standard deprivation of liberty applications had been authorised.

Staff understood the implications of the MCA and DOLS. People received care from staff who recognised the right of people to make decisions about how their care was provided. The manager had taken account of a recent High Court ruling affecting DOLS and was following advice from the appropriate authority in making additional applications. This ensure where people were subject to any form of deprivation of liberty, the necessary safeguards were in place.

To help keep people safe and protect them from possible abuse the majority of staff had received training in safeguarding. They knew what forms abuse could take,

Is the service safe?

how to recognise it and what to do if they saw or suspected it. There was guidance readily available to staff which included information about how and where to make referrals about any suspected abuse.

A relative told us about an incident which had taken place in the service in June 2014. We confirmed this had been reported correctly to both the Local Authority Safeguarding team and also to the Care Quality Commission. A GP confirmed appropriate action had been taken at the time and the person had received the medical attention they required.

A comprehensive medicines audit carried out by the provider during our visit confirmed people were protected from the risks associated with the unsafe storage and administration of medicines. Checks included records of controlled drugs and the disposal of surplus medicines as well as the completion of medicines training for relevant staff.

People were protected from the risks associated with the employment of unsuitable people to provide care and support. The provider had a robust recruitment policy and procedure in place. Recruitment files showed the procedure had been followed.

Although people told us staff had to work very hard, they said there were usually enough staff on duty to meet their needs and respond to call bells promptly. The manager determined appropriate staffing levels according to the numbers of people and their level of need/dependency. They confirmed this was kept under review and would be adjusted if this was necessary to keep people safe. Call bells were answered promptly and there was a calm atmosphere throughout the service on both days of our inspection.

The PIR provided evidence of a daily Heads of Department meeting which included reports on any recent accidents, incidents, health and safety issues, complaints and infection control. Any necessary guidance arising from these was then passed to staff. This ensured they were aware of any action required to maintain people's safety.

Is the service effective?

Our findings

Commissioners and healthcare professionals told us that pressure care had improved and people were now protected more effectively when they were at risk of pressure ulcers. However, we found previous concerns about record keeping had not yet been fully addressed as care records were not always up to date or fully completed.

We looked at six care plans and found people's health needs were identified and how they were to be met was detailed. Where people's assessed needs required specific monitoring, for example, of pressure care, fluid intake or nutrition, there were detailed records in place. Positioning changes were being recorded for people who were susceptible to skin damage. Optimum mattress pressure settings were now recorded and monitored. We checked six mattress settings and found they agreed with the person's care plan. Where people required monitoring of their food and fluid intake, records showed this was being done. In most, though not all cases, regular weight records were kept and action taken to address any significant falls or gains in weight.

Individual dietary needs were met and people's personal preferences, for example for vegetarian options or halal meat were respected

As part of this inspection we asked health and social care professionals, for example, G.Ps and commissioners, for information to support the inspection process. We received information from five of these including community nurses and tissue viability nurses. In each case they said they had noticed significant improvements in records and skin care over the past month. We also spoke with a GP who told us the service had improved since January and was now more effective. Several of the staff also told us they thought record keeping and care records had recently improved

Dining rooms were well-laid out and provided an attractive setting for meals. We observed people having breakfast and lunches in different parts of the service. Staff interacted positively with people. They spoke calmly and asked people what they would like to eat and drink. We were told where people needed it; plated meals were shown to help them make an informed choice. A visitor was able to sit and eat with their relative. During an observation in that part of the service where people who lived with dementia ate staff were sitting and eating with people. One person who was not eating much was very gently encouraged to have some trifle. Where people required assistance to eat, this was done patiently and at a pace that suited the person who was eating. However we did see one person had fallen asleep with their meal in front of them. We drew this to the attention of staff who then helped the person to finish their meal.

People had access to wheelchairs and walking frames. Bathing facilities were appropriate for people with reduced mobility.

People had access to community health services, for example, GPs, dentists and opticians. People's care plans included records to support this. One GP told us they received the information and co-operation they required from staff to provide effective support to people. People and their relatives were involved in regular reviews of their care.There were meetings for people who use the service where menus and meal choices could be discussed.

Training and appraisal records showed staff were being supported by regular supervision. Staff told us this enabled them to raise any concerns or request specific training with their line manager.

We saw a record of staff training and how this was monitored. This was broken down by role and training subject and meant the manager could monitor where there were any shortfalls and take appropriate action. Staff confirmed they had received regular training and supervision. We confirmed from care assistant supervision records this was taking place at least every three months. One member of staff told us they didn't always; "Feel appreciated", however, the majority of the 14 staff we spoke with told us they felt supported by the manager and management team.

There were daily meetings of heads of department with relevant information cascaded to other staff. Handover meetings were held on each floor at shift changes, which meant staff were made aware of recent developments with people who received care and support and were able to take these into account when they provided care.

Is the service caring?

Our findings

We spoke with 13 people who lived in Windmill Care Centre. The comments we received were overwhelmingly very positive; "I'm so happy here", I'm at ease", "Lovely people here" and "Heaven on earth" were some of these.

Although we noted very positive interaction between care and nursing staff and people who lived in the service, we also found staff had limited time for 'casual' non-task focussed interaction. Staff told us they tried to find time for 'social conversations' with people; however they were always conscious they needed to meet people's physical needs as a priority. People told us however that they felt well-cared for. "Great carers, all lovely"

Relatives told us they felt they were involved in their relative's care and were able to influence decisions about their care and welfare. One told us the service was very proactive in contacting them about any issues; "I am reassured that they would let me know about anything significant, communication is very good". Another relative confirmed they had ready access to their relative's care plan and were kept informed of any developments. "Staff are lovely" was one comment they made.

Not all of the care plans included a completed advanced care plan. These set out people's wishes at the end of their life and are intended to ensure care is provided at that time in the way they wanted. Staff told us it was not always possible to obtain this information as some people and their families were reluctant to discuss it.

Staff treated people respectfully. They listened to what people said and appeared sensitive to their mood. People told us they felt their dignity was maintained, for example when they received personal care. We observed staff approached people and talked with them in an appropriate way. Staff encouraged people to maintain their independence and abilities, for example when eating and provided any necessary assistance sensitively. Where people lived with dementia staff provided reassurance by holding their hand for example and speaking slowly and clearly.

We arrived early in the morning and we listened to care staff helping people get ready for the day. There were very positive interactions, gentle tones and a calm atmosphere. Staff ask them how they were, if they had a good night and what they wanted to do.

Staff talked with people about everyday things such as the weather; "We will see if we can sit in the garden later – we will find you a nice hat and have a cold drink". The observations we carried out at mealtimes over the two days of this inspection, including breakfast, confirmed people were given choices about where, when and what they ate. One person's care plan noted they liked to choose their own clothes and were very particular about how 'smart' they were. We saw they had dressed themselves, with assistance in a way which reflected this.

Staff were, in most cases, able to tell us how specific individuals liked their care provided. People did not raise concerns about staff consistency, other than saying it was better for them when they knew their carer. We were told the use of agency staff had been reduced following recent recruitment of permanent staff. When agency staff were used, it was always the aim to use staff that were familiar with the service and the people who lived there. This meant people were usually provided with care by people they knew and who knew them and their care needs.

The service had appointed 'Dignity Champion' whose role was to ensure all staff were aware of and followed good practice. The service encouraged people to make meaningful choices through care planning, reviews of their care involving them and people important to them meetings of people who use the service and encouraging relatives to provide information about people's life histories wherever possible.

Is the service responsive?

Our findings

One relative told us they felt care staff sometimes didn't take into account the person's habit of getting up and dressed very early. This meant they didn't give them a shower as they thought they were already washed. They said they would raise this at the next review of the person's care and were confident it would be sorted out. They were otherwise very supportive of the care provided and the quality of the care staff.

People's individual needs were assessed and their preferred way to have them met was established with their involvement. Staff were provided with training in, for example, dementia care, to ensure they could provide effective and responsive care for those people who lived with dementia. Where people had specific nursing needs, trained staff and appropriate equipment were in place to meet them effectively.

Care plans included variable amount of details about people's interests, significant events and people in their lives and sometimes none. We were told this information was often provided by relatives and could take time to be obtained. The more information obtained about people's life history there was, the easier it was for care staff to provide effective individual care that took this into account.

We saw minutes of a relative's meeting held in March 2014 and a resident's meeting held in April 2014. The relative's meeting was poorly attended. Discussion included labelling clothes, redecoration of bedrooms and activities for people who lived with dementia.

The resident's meeting minutes included comments from people about the quality of their care; "I feel very safe all of the time and I have a sense of freedom. If I want to go to another floor or the garden, I ask the staff and they help me." Another person said they enjoyed "always being given a choice of clothes, food and drink." People were asked for any comments about food, activities, laundry, staff and their overall well-being. This showed they had the opportunity to make comments and suggestions about important areas of the service's operation that affected them. The activities co-ordinator, who was present at the meeting, told us they took account of people's views when deciding what activities to arrange. For example, people were recorded as asking for more trips out and the co-ordinator told us they were trying to achieve this during the summer.

Three relatives said the recent illness of one of the activities organisers had led to a reduction in trips out of the service. Activities were taking place during the two days of our visit. We observed one session of floor snakes and ladders with two people taking part. We spoke with one of the activities organisers. They told us about one to one sessions they carried out with residents as well as organised sessions for all. One to one contact enabled staff to follow up people's particular interests or hobbies with them. They said they had resources provided, for example they used Age Concern's reminiscence material. They told us they aimed to go out from the service each month. They accepted this could not include all the people who lived in the service, because of transport limitations and that recently fewer trips had been possible.

The activities programme included sessions in both morning and afternoons and at weekends. These included arts and craft, games, chair aerobics, papers, discussions, crosswords and quizzes.

Care plans included regular assessments of the level of people's need along with assessments of their overall well-being. Any changes were noted and action taken to address them. This meant people's needs were being effectively monitored and care plans amended to take account of any changes over time. Although relatives said they were involved in reviews of people's care the active involvement of people or their relative's was not always clearly reflected in the care plan.

People were encouraged to remain as independent as possible. People were able to maintain contact with friends and family. Staff recognised frequent visitors and engaged with them. One family member had lunch with their relative and told us they came in very frequently and felt staff were; "Part of the family".

An audit of care files completed by a senior manager on the 11 July 2014 found care plans were not always fully completed. For example, some bed rail assessments were incomplete, records of monthly checks, for example of weight were not always completed and specific assessments of, for example pain and depression had not

Is the service responsive?

been consistently recorded. An action plan and additional staff training was in place to monitor progress in addressing this and to ensure records reflected accurately the care actually provided.

People knew how to make a complaint if they needed to. They told us they felt able to raise concerns with care staff and nurses or with the manager informally and had found the manager and staff were very responsive when they did. There was a formal complaints procedure in place, and this was readily available to people who lived in Windmill Care Centre as well as relatives and visitors. In the information provided by the service prior to the inspection, they told us in the preceding 12 months they had received and resolved five complaints about the service. In the same period, 12 compliments had been received.

We were told in response to a complaint about one person's clothing becoming misplaced, the home had improved the level of checking of people's laundry and clothes storage in their rooms. They had also reminded relatives about the need to clearly label clothes and reminded staff how to support people who lived with dementia who might misplace clothing within the home. This approach had been welcomed by the person making the complaint and had helped to improve practice in a practical way.

Is the service well-led?

Our findings

The service manager confirmed they had worked closely with the local authority care commissioning team and health and social care professionals in order to address previous concerns about the standard of records and pressure care, particularly for people living on the first floor. They had drawn up an agreed action plan and were working towards its completion by the end of July and going forward.

Additional management resources had been put in place. A deputy manager was now in post. The registered manager had received regular support from senior managers and was also being supported through the input of another registered manager.

Visiting health care professionals told us there had been "significant improvements" in care practice in the past six months in particular. They confirmed the service were responsive and receptive to advice given, for example in respect of skin and pressure care. Commissioners told us the service had been co-operative and responsive during this process. We were subsequently informed the restrictions previously put in place on admissions to the first floor had been relaxed.

Relatives and people who lived in the service told us the manager was approachable. One relative told us they found they were "Genuinely interested" in their relative's care. They said communication was good, they felt their views and opinions were taken seriously and that there was a genuinely collaborative approach to meeting their relative's needs.

People were involved in reviews of their care, along with their relatives where appropriate. There were regular meetings of people who lived in Windmill Care Centre as well as relative's and staff meetings, although relative's meetings had been poorly attended. These meetings provided opportunities for people's active involvement in developing the service.

There was a system to record accidents and incidents within the service. Where it was possible to do so, action was taken to prevent these from happening again. The service had notified CQC appropriately of incidents and significant events as required to by law.

We were provided details about a person who had recently fallen. A system for tracking falls was now in place on their care plan. This meant staff could monitor and identify any patterns to subsequent falls and take appropriate action to prevent them where that was possible. The person's falls risk assessment had been updated.

Staff told us the manager was supportive and said the deputy manager had been a positive help. Staff said they felt they had been helped through intensive training over the period to improve care planning and documentation. Staff were supportive of one another and of the service. Whilst they said they worked very hard they told us good teamwork and co-operation between nursing, care and management staff made their job easier and the service a better place to work. "We are a strong team" and "We work well together" were two of several positive comments made during our interviews with staff at all levels.

We saw minutes of a staff team meeting held on the 1st July 2014. This recorded opportunities for the exchange of information, discussions about good care practice and an update on current issues affecting the service. There were opportunities for the staff team to reflect on how effective their care practice was, look at examples of good practice and receive updates from the service's management. For example, In response to concerns raised by commissioners, staff told us they had received additional training and had reviewed their care practice and record keeping. They said record keeping and how care was delivered had improved as a result.

People were protected by a system of audit, review and monitoring by the provider. This helped raise standards of practice and facilitate improvements where they were identified as necessary.

We met with the operational director responsible for quality audits and received a copy of their report of July 2014. This was thorough and comprehensive and required an action plan/response, with completion time, to be actioned where any shortfalls or issues were identified. We received a copy of a medicines audit carried out at the same time.