Keslaw Limited

Woodcot Lodge Care Home

Inspection report

12 Rowner Road
Gosport
Hampshire
PO13 0EW

Tel: 02392520085
Website: www.fshc.co.uk

Date of inspection visit:
12 April 2016
14 April 2016

Date of publication:
21 June 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out this unannounced responsive focussed inspection on the12 and 14 April 2016 to see if the provider had made progress following the last two comprehensive inspections. The last two comprehensive inspections were carried out in March 2015 and September/October 2015 which had led us to follow our enforcement pathway. Since these inspections we have continued to be notified by the provider of significant events and concerns which were raised to us, all of which have been reported to the local safeguarding authority. We also received information of concern from external sources. We have received action plans from the provider informing us what action they are taking to make improvements and achieve compliance. We received an updated version of the action plan from the provider during this inspection. The previous one had been received on 8 December 2015.

This inspection took place on 12 and 14 April 2016. Woodcot Lodge is a nursing home which offers personal and nursing care for up to 85 older people, some of whom live with dementia. The home has three floors, with a lift providing access to all floors. The second floor accommodates people living with dementia and the first floor accommodates people with nursing care needs. The ground floor is referred to as 'residential' and accommodates older people who do not fall into the other two categories. At the time of our inspection 61 people were living at the home.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are registered persons". Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

A week before the inspection the local authority safeguarding lead wrote to us, to inform us their staff had noted recent improvements in the home. The provider contacted us two days later to inform us they were closing the top floor, as they wished to focus on providing good care on the ground and first floor. They had recognised the care they were offering on the top floor was not up to the standard they expected to provide.

As a result of this information and feedback we undertook a responsive inspection to look at what the current position was and check on the progress of the previously breached regulations. This report only covers our findings in relation to our unannounced inspection on the 12 and 14 April 2016 about progress in relationship to the previous breached regulations. The previous breaches related to safe care and treatment, nutrition, person centred care, consent and good governance. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link of Woodcot Lodge on our website at www.cqc.org.uk.

We found progress had been made in all areas, but there was still room for improvement, but the impact on people was low.

Risk assessments had not been completed for all people to ensure staff were aware of the risks facing

people.

People were supported in a respectful manner to ensure they received a balanced diet.

People had their mental capacity assessed and best interest decisions had been made appropriately.

All people were not receiving personalised care.

Quality assurance processes and record keeping had improved but here were still shortfalls in these areas, which had not been identified or addressed.

We found repeated breaches in three of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to the shortfalls we found during this and previous inspections. Where providers have not been meeting the fundamental standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

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 always safe. Risk assessments were being completed, but there was still the need to ensure these were specific and completed where there were identified risks.

Is the service effective?

Requires Improvement

The service was not always effective. Some improvements in the consistency of practice were needed. Staff had knowledge of the Mental Capacity Act 2005, restraint and of the need for best interest decisions.

Is the service responsive?

Requires Improvement

The service was not always responsive. Whilst some improvements had been made, people did not always receive personalised care, which was in line with their needs or preferences.

Is the service well-led?

Requires Improvement

The service was not always well-led. Whilst some improvements had been made, people's records were not always accurate and well maintained; the quality assurance process did not identify or address all the issues needed.

Woodcot Lodge Care Home

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 was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspections had been made. We inspected the service against four of the five questions we ask about services: is the service safe, effective, responsive and well-led. This is because the service was not meeting legal requirements in relation to these questions

This inspection took place on the 12 and 14 April 2016 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor in the care of frail older people, especially people living with dementia and those with end of life care needs.

Before the inspection we had updates from the provider and the head of safeguarding from the local authority. We had reviewed previous inspection reports, action plans from the provider, safeguarding meeting minutes and notifications. A notification is information about important events which the provider is required to tell us about by law. During the inspection the provider sent us an updated detailed action plan.

During the inspection we spent time talking to the registered manager, the head of care improvement and the resident experience care manager. We looked at the care records of eighteen people. We spoke with ten people, three visitors, three professionals, two registered nurses and seven care staff.

Requires Improvement

Is the service safe?

Our findings

We had previously identified at our inspections in March 2009, February 2014, June 2014 September 2014 and March 2015 a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This correlated to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In September /October 2015 we found a breach of Regulation 12, of the Health and Social Care Act 2008 (Regulated Activities) relating to the safe care and treatment of people. We had found people did not have appropriate risk assessments to ensure staff knew the risks to people. Risk assessments had not been recorded to show how the risk could be minimised and therefore staff had not known how to keep people safe.

During this inspection we found there was more information in most people's records in relation to risk. Most people had risk assessments in key areas of their care provision. For example in the areas of moving and handling, falls, nutrition, Malnutrition Universal Screening Tool (MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese) and skin integrity, risk assessments had been completed. However there were still people who did not have appropriate risk assessments in their care records so staff would know how to support them whilst minimising the risks.

Some people had more personal risk assessments, but these had not been completed for all people. For example, daily records or associated charts recorded people's behaviour, which indicated there should be a risk assessment. When looking at one person's monthly dependency assessment in the areas of medication and mobility we could see their dependency rating had changed from medium to high. However there was no associated risk assessment to detail why the person's needs had changed and what the associated risks were with these changes.

In another example, one person's nutritional risk assessment had boxes ticked regarding particular risks, which did not apply to the person. These indicated there was a high risk of malnutrition because the person was having "Subcutaneous fluids" and "Problems relating to a feeding device such as a PEG". The clinical Lead told us, "This is not correct, they do not have sub cut fluids and they do not have a PEG". This error had not been picked up in the services own monthly reviews. This meant the risk assessment was not relevant to this person, and they could have received inappropriate and unsafe care. In other examples there was recording of people's behaviour affecting other people, staff and visitors, but there were no appropriate risk assessments in place.

Although we found appropriate risk assessments were not in place for all people, staff were aware of how to care for people and the impact of not having appropriate risk assessments was low. For example one person was walking without a walking aid; two staff in succession asked the person where their walking aid was, which minimised the risk for this person, as their walking aid was located. In another example staff told us how they managed a person's behaviour at lunch time, which had been identified as a risk to other people. Whilst this risk was not recorded in the person's care plan staff were aware of the risk and took appropriate action to minimise the risk.

There were other examples throughout the inspection where we saw evidence of risks not being taken into account to provide safe care. For example, on one floor we saw tins of "Thick and Easy" (this is a powder designed to easily thicken foods and fluids for people who have difficulty swallowing) left on the trolley which was unsupervised for long periods, in a corridor where people were moving around nearby. This could have presented a potential risk as highlighted in a Patient Safety Alert issued in February 2015. This alert followed two deaths, one in a care home where a person ingested a large volume of dry thickener. The warning includes guidance about the safe storage of thickening powders and risk assessments to determine if there is any risk from any person in a care home attempting to drink the dry powder. The provider had not followed the Patient Safety Alert guidance. In another example we saw an agency nurse give a staff member a pot of tablets to take to the person. The administration of medicines was the responsibility of the nurse who dispensed them and it was not a safe practice to give them to another staff member to administer. We spoke to the manager about this who told us "This is not acceptable practice".

We found errors with people's records regarding their nutritional and hydration needs, which increased the risks for these people. For example people with Dysphagia (people who have difficulty in swallowing) are at high risk of malnutrition, dehydration, aspiration pneumonia and choking. A key element in reducing the risk of choking and aspiration when drinking is to modify the texture with the adding of fluid thickener. Risk assessments for choking had been completed, but records did not provide a consistent record of people's requirements for fluid thickener. For one person, their records did not establish if the person should be on food thickener and if so to what consistency their food should have been thickened to.

Whilst there had been some improvement regarding people's risk assessments the breach of this regulation remains.

The lack of effective risk assessments in place to ensure the safety and welfare of people was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

At our inspections in June 2014 and March 2015 we identified a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This Regulation correlates to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found this Regulation was still in breach at our inspection in September/October 2015. We found people had not been supported in a manner which meant they had their nutritional needs met. At this inspection we found the provider was now compliant with this regulation.

During this inspection we found people were supported at meal times by staff who treated people with respect and dignity. Almost all interactions at meal times were positive and showed staff were caring and patient.

People's records showed most people had regular checks carried out associated with their nutrition. For example a Malnutrition Universal Screening Tool (MUST), had been carried out monthly. Where necessary we could see people had been referred to the GP and Speech and Language Therapist (SALT) if necessary.

Most people's nutritional care plans detailed personalised information relevant to the person. For example the need for specialist cutlery or crockery were detailed. People's food preferences were recorded. One person told us, "I get my coffee, not tea, just as I like it". They told us they were pleased they were able to have a small fridge in their room.

Meal times were well organised and the atmosphere in the dining rooms was calm. People did not have to wait for their meals and people told us they enjoyed their meal. Staff prompted people to eat who required a little support while other staff supported other people to eat. Staff were competent and kind, they were patient and the interactions with people during this meal time were good ensuring this was a positive experience. We observed staff supporting a person who was recorded as having 'high' needs at meal times. A care staff member spoke very quietly to the person about the food and how it had been prepared especially for the person. This was a calm experience and one which facilitated the person to meet their nutrition and hydration needs.

There was adequate staff to ensure people's needs were met. Staff spoke respectfully and discreetly about people in terms of what meals they were having and had eaten. Staff did not talk over people whilst they were providing support. Staff knew what food people liked to eat and when one person refused their dessert they were offered an alternative which they enjoyed. Staff had a good understanding of the care and support people needed to ensure they had enough to eat and drink.

At the last inspection in September/October 2015 we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regarding the lack of consideration of people's mental capacity and best interest decisions. At this inspection we found the provider was now compliant with this regulation.

Staff had received training and understood the Mental Capacity Act and Deprivation Of Liberty safeguards. 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. Assessments had been carried out to assess people's capacity. Whilst in most people's records it was clear restrictions had been considered and recorded there was a need to ensure this was consistently put into practice. For example if door sensors are put on to prevent people wandering into another person's rooms this must be considered a restriction for everyone.

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 manager and staff had an understanding of the Deprivation of Liberty Safeguards (DoLS) and staff had received training to support their understanding. Records of applications to deprive people of their liberty were recorded in people's records.

Requires Improvement

Is the service responsive?

Our findings

We had previously identified at our inspections in February 2014, June 2014 September 2014 and March 2015 a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This correlated to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In September /October 2015 we found a breach regarding Regulation 9, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as care and treatment had not always been person centred and people's needs had not been met in an appropriate way.

Whilst we could see an improvement in people receiving personalised care the regulation was still in breach as not all people were receiving personalised care.

The process of assessing and planning people's care had not changed since the last inspection. People's care plans were split into sixteen sections and each section was reviewed on a monthly basis. Records included my choices booklet, daily journals, and daily records which included the delivery of care.

The handover sheets on each floor detailed basic information on people's needs. On the first day the handover sheet held by all staff working on one floor had no codes (the codes related to important information, for example, re-positioning, thickening fluids, bed rails and food and fluid charts). None of the staff were able to tell us what the ticks on the handover sheet related to. This meant staff did not have a quick way of accessing people's basic needs. On another floor it was noted some of the information recorded was incorrect, again meaning staff did not have to hand information on people's needs.

The way the care plans were written and organised meant it was sometimes difficult to get an accurate picture of the person's current needs and sometimes the information had not been recorded. The most up to date information was not at the front of the section which meant staff had to search each of the sixteen sections for the most up to date information. Information was not always recorded in the most obvious section. For example someone who was identified as having frequent urinary tract infections did not have this information recorded in their 'continence' care plan, but in their diabetes care plan.

It was not always possible to establish all the information had been reviewed when monthly reviews took place. For example it was noted one person had two potential falls in successive days, with bruising noted in records on both days. After one of these incidents records indicated there was bruising but no photographs or measurements were undertaken. The records also made reference to 'a little pain', but with the absence of a pain assessment it was difficult to establish how staff knew what a little pain meant for the person. This information had not been picked up in the monthly review.

In another example, the skin integrity care plan of a person stated they had a small unbroken area at the base of their spine. A body map was available but there was no photograph and there were no further references to this skin damage after the date in any risk assessments or care plans. A protective product which protects the skin had been prescribed and should have been applied after all personal care to reduce the risk of moisture damage and pressure damage occurring. The person's records showed the cream had

not been applied after all personal care was given.

We saw in people's records the Older Persons Mental Health Team visited the home on a regular basis. A senior member of this team told us, "The home has improved quite a bit over the past six months. It was a concern before, but they are still disorganised. When I come in to assess a person at their request, the information is not available. This is very frustrating and not an effective use of our time". They did report they were hoping to make links with a new member of staff and thought the situation would improve so people could be offered more personalised care.

Whilst it was clear there had been efforts to make care plans more personalised, there was little evidence from the records that people and their relatives had been involved in the reviews of the care plans. Efforts had been made to record people's choices and preferences but it was not always possible to evidence these choices had been offered. For example one person had recorded they wanted a bath in the evening. However it was clear from records in the last six weeks they had only been offered a bath twice. It was not possible to establish the time the bath or showers had been offered.

The care and treatment of people was not always person centred and did not always meet people's needs in an appropriate way. This was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

We had previously identified at our inspections in February 2014, June 2014 and March 2015 a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This correlated to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In September /October 2015 we found a breach regarding Regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; regarding the quality assurances processes in the home and the record keeping.

During this inspection we found the quality assurance processes and record keeping had improved and there were more efforts to ensure the quality of the service provided was monitored. However whilst there was improvement there was still errors which the quality assurance system had not picked up and there were still errors with records.

The provider had recognised from the analysis of information and audits that the service offered on the top floor had not met their own standards and was taking steps to close this floor. The provider advised they wanted to ensure the care provided on the remaining two floors was of the standard they expected and it would give them time to ensure staff had the training and support needed to acquire the necessary skills, to meet people's needs.

The quality of the service was being monitored from reviewing the quality of care with individuals to reviewing the provision of the service as a whole. The audits carried out were analysed and reports were made of the action needed. The following audit picked up the list of actions and reported on whether they had been completed. For example daily medications and care plan audits identified any errors and these were addressed at the next audit. Whilst it was clear from the amount of audits being undertaken the provider had made improvements in quality assurance there was still errors which were not being picked up by the audits. We found there were several aspects of risk which were not managed appropriately or safely although we found there had been improvements at the home overall. We found several incidents had not been reported using the home's reporting system, which meant the current audits were not showing a true picture of risk management at the home.

We found incomplete records relating to medicines, food and fluid thickener, skin care and treatment and concerns of relatives and incidents. For example, weight charts were maintained for people, but for one person who had lost weight the record had not been maintained since the 1 March 2016. The Clinical Lead told us, "This person should have weekly weights but it has not been done, or if it has it has not been recorded". No records could be found. This meant risks were not adequately monitored and the overall monitoring of quality assurance was incomplete. The manager and lead staff told us the home was "Work in progress" and they were not surprised by our findings. During the inspection lead staff corrected omissions when we pointed them out. This was a positive response which had not happened in the past.

Whilst there had been improvements in the quality assurance system and records we still found concerns with quality assurance and records. This was a repeated breach.

The provider had failed to operate an effective system to monitor the service to drive improvement and maintain accurate records, which was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.