Anchor Trust

Woodland Grove

Inspection report

Weston Park
Weston Village
Bath
Somerset
BA1 4AS

Tel: 01225464004
Website: www.anchor.org.uk

Date of inspection visit:
12 April 2016

Date of publication:
18 May 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 a comprehensive inspection of Woodland Grove on 15 September 2015. Breaches of the legal requirements were found. The breaches related to the care and safety of people using the service, as well as matters relating to medicine management, nutrition, consent and the running of the home.

The breach relating to medicine management had been repeated from a previous inspection in April 2014. We issued a warning notice. This meant we told the provider the date they were required to meet this legal requirement.

After the inspection, the provider wrote to us to say what they would do to meet the legal requirements for the other identified breaches.

We undertook a focused inspection on 12 April 2016 to check the provider had followed their plan and to confirm they now met the legal requirements. This report only covers our findings in relation to these areas. You can read the report from our last comprehensive inspection by selecting the 'All reports' link for 'Woodland Grove' on our website at www.cqc.org.uk

Woodland Grove is a 50 bedded home that provides accommodation for persons who require personal care. At the time of our inspection there were 31 people living in the care home.

There was no registered manager in place at the time of our inspection. The manager in charge of the home told us they had submitted an application to the Commission to become the 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.

At our focused inspection on 12 April 2016, we found that sufficient action had been taken and the provider now met the legal requirement relating to the management of medicines. We continued to find breaches relating to the care and safety of people using the service, as well as matters relating to nutrition and hydration, record keeping and the running of the home.

Risks to people were assessed, however actions were not always taken to mitigate the risks and keep people safe. Where people were at risk of malnutrition and dehydration, accurate records were not always maintained.

The provider ensured the service was responsive to providing people with personalised care. Care plans that had been recently reviewed reflected people's individual needs, preferences and choices had been considered.

We found the provider had not ensured governance systems were robust to monitor and mitigate the risks relating to the health, safety and welfare of people. People's records were not always accurate and completed correctly which placed them at risk of unsafe or inappropriate care.

We found three breaches of the regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

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 completed. Actions were not always taken to minimise the risks of harm to people

People were protected against the risks associated with management of medicines. People received medicines when they needed them and in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.

People were protected against the risks of malnutrition and dehydration. However, the supporting records were not always accurately maintained.

The provider had acted in accordance with the Deprivation of Liberty Safeguards and when needed, people were being lawfully deprived of their liberty.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provider ensured personalised care was delivered to people. However, the supporting records were not always in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Governance systems to monitor the safety and quality of the service were not always robust.

People's records were not always accurate and up to date.

Woodland Grove

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.

We undertook a focused inspection of Woodland Grove on12 April 2016. The purpose of the inspection was to check whether the improvements we required and improvements planned by the provider after our inspection on 15 September 2015 had been made.

This involved inspecting the service against four of the questions we ask about services: is the service safe, effective, responsive and well-led. This was because the breaches found at the last inspection were in relation to these questions.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by two inspectors, a pharmacist and 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.

Before carrying out the inspection we reviewed the information we held about the care home. This included the report we received from the provider which set out the actions they would take to meet the legal requirements. We also looked at the notifications we had received. Notifications are information about important events which the provider is required to tell us about by law.

During our inspection we spoke with nine people who lived at the home and with one visitor. We also spoke with the manager, two senior managers, four members of staff and two agency care staff. We made observations of staff interactions with people during the day and we observed medicines being given to people.

We looked at eight people's care records. We also looked at medicine records and records relating to the monitoring and management of the care home. We reviewed the progress with the provider's action plan which they had submitted to us following the last inspection.

Following the inspection we received information from a health professional who provides regular support to the care home.

Requires Improvement

Is the service safe?

Our findings

When we inspected Woodland Grove on 15 September 2015, we found risks assessments and care plans did not always ensure people would receive safe care. Risk assessments were not up to date and the care plans did not provide detailed information about how to safely care for people with identified risks to their safety and well-being. This was a breach of Regulation 12 (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 12 April 2016, we found some improvements had been made. Risk assessments had been completed and they were up dated on a monthly basis. However, whilst risk assessments and management plans were in place, the required actions were not always followed. For example, some people were checked as often as their risk management plan stated and their records were not fully completed. This meant some people were still not being cared for safely.

Some people were unable to verbally express their views. However we also spoke with people who told us they felt safe. Comments included, "If I need help and use the call bell it is answered within a reasonable amount of time" "I do feel safe because the staff are so helpful and step in before there is a real problem" and, "They do come and check on me sometimes as I do spend time in my room." However, we found safe care was not always delivered.

We noted for one person the care records stated on the 11 April 2016 that care had not been provided as planned. Hourly checks had not been completed because of the "Lack of staff". These were entries completed by agency staff. This was for a person who required hourly checks because they had a history of falls. Their risk assessment had been reviewed in March 2016 when the GP had been consulted and the person had been referred to the falls clinic.

For another person the care records on 11 April 2016 noted they had not been given their food and fluids at the usual times. An entry at 11.15am stated, 'Late breakfast given due to lack of staff' and at 1.30pm 'Lunch given. No fluids given due to lack of staff.' This was a person assessed as high risk, who had lost weight and was prescribed supplementary fluids. The manager told us the agency staff who had completed the entries had not reported any concerns on the day they worked in the care home. The manager told us they would investigate the matter immediately.

For some people, falls and accident monitoring records were partly completed. For example, when people fell, the provider's monitoring tool guidance stated they should be observed regularly, following the fall, and at the start and end of the shift. This frequency of monitoring after a fall had been completed in some, but not all of the records of people who had fallen. For example, one person had fallen on three separate occasions since October 2015. There was one post fall entry on one occasion following their fall. Another person had fallen during one morning. The records did not confirm how frequently they were monitored before they were transferred to hospital later that evening. The records did not confirm this had taken place so it was not clear when they had started showing signs of being unwell and in pain.

In one person's daily record, night staff had written for the night before our inspection that a person had been found in the bed of another person. The daily record stated "(person's name) was in (person's name) bed. Took him back to his room". There was no further detail recorded. A senior member of staff told us the incident had not been reported at handover by the night staff. They later established the person had been sitting in their chair when the other person got into their bed. The person was not distressed or upset by the incident. However, this was not recorded at the time. The manager contacted us after the inspection and told us they had reviewed the risk assessment for the person and completed an action plan to ensure the safety of people in the care home.

This was a repeated breach of Regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff who told us the staffing levels were improving as new staff were being recruited. Staff also told us, "We pull together if we're short and work as a team." Another member of staff told us, "Things are improving here, now we have a new management team."

We looked at the staff rotas for the preceding month and found several days when staffing levels were supplemented with regular and planned use of agency staff. On the 11 April 2016, four agency care staff worked in the home. In addition to the staff vacancies, there had been an outbreak of Norovirus. This meant that staff were unable to return to work until they were asymptomatic for 48 hours. The staffing levels were in accordance with the levels determined by the provider's dependency tool. This is a tool that calculates the numbers of staff required to meet the needs of the people living in the home. This meant there were enough staff to meet people's needs.

We spoke with the agency staff working in the home on the day of our inspection. They told us they had received a handover and had been given information about the people they were allocated to care for. One agency staff commented, "I think this is one of the better homes to work in."

Risks within the environment had been assessed. For example, the new manager told us they were concerned about the access people had to the open staircases. A risk assessment had been completed and a risk management plan was in place. This stated the risk was currently controlled. However, the manager told us they would need to review and consider the risk each time they admitted people to the care home.

During our inspection on 15 September 2015 we found medicines were not always stored, recorded, administered or disposed of safely. This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected on 12 April 2016 we found there had been improvements to the way people's medicines were being managed since our previous inspection. People's medicines were now being managed safely. Systems have been put in place that ensured medicines were ordered, stored, administered and recorded in a way that protected people from the risks associated with them.

There were safe systems for storing medicines, including items needing to be stored in a refrigerator. There were systems in place to monitor the temperature to make sure that medicines would be safe and effective for people. Arrangements for checking and recording any controlled drugs were in place.

People were not looking after all of their own medicines at the time of the inspection, but systems and policies were in place to allow them to do this, if it had been assessed as safe for them. Medicines were administered in a safe way to people at lunchtime. People were asked if they needed any medicines that

were prescribed 'when required', for example pain relief.

There were systems in place to guide care staff on how to apply creams and to record when these were applied to people. Medicines record charts were fully completed, showing that people received their medicines in the way prescribed for them.

There was an audit trail of medicines received into the home and those sent for disposal. This helped to show how medicines were managed and handled safely in the home. New audits had been introduced to help make sure that medicines were managed safely, and we saw that any issues were picked up, reported and handled appropriately. Staff had received training updates, and checks had been updated to make sure they gave medicines safely.

Policies and procedures were available to guide staff, and information was available for staff and residents. Staff had received training and their competency was checked by senior staff, before they were allowed to administer medicines on their own.

We found sufficient actions had been taken to meet this legal requirement.

Requires Improvement

Is the service effective?

Our findings

When we inspected Woodland Grove on 15 September 2015 we found people were not fully protected against the risks of malnutrition and dehydration. There was a lack of guidance for staff to follow and people's conditions were not monitored in accordance with their assessed need. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 12 April 2016, we found improvements had been made.

People told us they were satisfied with the food provided in the home. One person commented, "The food is ok, not always what I would choose but really we can't grumble". We saw the chef speak with people in the dining room. They chatted with people and asked for opinions about the food. They explained a new summer menu was being introduced and asked people to let them know if there were meals they didn't like. They said, "The kitchen are trying to get individual meals just right to suit your and the other residents' preferences".

The care home used a nationally recognised screening tool to assess people's risks of malnutrition. Where people had been identified as being at high risk of malnutrition or dehydration, care plans were in place. However, we found that guidance within the care records was not always followed by staff. For example, one person had been assessed as high risk of malnutrition on 24 February 2016. The person had lost weight and had been referred to the GP. The care plan informed staff to weigh the person weekly. There had been gaps when the person's weight had not been recorded on three occasions.

We spoke with staff who told us some of the weight recordings may not have been taken, due to staff sickness, staff vacancies and high use of agency staff. The senior managers told us they had recognised the guidance in the care plans was not always followed and there had been omissions in monitoring people's weights. In response, they had introduced a system for people who needed to be weighed each week. These had been completed and were up to date for the two weeks prior to our inspection.

Some people had their fluid intake monitored and recorded. One person's records showed they had a very variable fluid intake over a period of four days. On two days, their intake was significantly below what would be expected for an adult. The records did not show this was noted or reported to senior staff. However, when we brought this to the attention of senior staff, they told us they were aware and they were aware of the variation we had noted. The records did not provide confirmation this had been acknowledged.

A senior manager told us they were aware of people's food intakes. They told us they had recognised that staff knowledge was limited with regard to people's individual needs, preferences and choices. They showed us a 'location dietary summary' sheet they had introduced. This provided detailed information, in addition to the detail in the care plan, about people's specific needs, preferences and choices. This was discussed at daily staff meetings and handovers and reviewed each week. The updates were communicated to care staff and to the chef. For example, for one person, their preferences were recorded as, 'Likes crusty bread and butter with cheese for lunch' 'Cooked meals for supper, dislikes fish, likes beef well done' and for another

person their requirements included, 'no grapefruit-on statins-enjoys cooked breakfast with eggs, beans and toast. Low salt. Plate guard'. The summary sheet provided a quick reference guide, especially as the home was reliant on the use of agency staff, and new staff were being recruited.

Records showed that the people were referred to health professional when their condition and needs changed. For example, we saw involvement of the Speech and Language therapy (SALT) teams. People's diets were modified as had been prescribed by the SALT team. One person had been recommended to have a textured diet, and the details were recorded in their care plan. The person had a risk assessment completed because they sometimes decided to eat cornflakes. This type of textured food was not recommended. However, the person had the capacity to decide what they wanted to eat. They had been made aware of the possible risks to their health. However, their right to choose was respected.

People were monitored when they had fallen, and people were referred to the falls clinic when needed. One person had their medicine changed and had been moved downstairs because of the risks posed by the open staircase.

We received information from a health professional who provided support to the home on a regular basis. They expressed some concerns about the abilities of the staff team to meet the needs of people with increased care needs or who were receiving end of life care. At the time of inspection, there were no people receiving end of life care. In the care records for one person, a health professional had recorded at a recent review, "Woodland Grove must request a review should they become unable to meet her high care needs and should liaise frequently with the GP and district nurse team." The district nurse had visited on the 5 March 2016 and their comments were recorded as, "District Nurse came today to check her pressure areas and said no problem at this time."

We found sufficient actions had been taken to meet this legal requirement.

When we inspected Woodland Grove on 15 September 2015 we found that some people had Deprivation of Liberty Safeguards (DoLS) in place. DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to care and treatment and need protecting from harm. We found the provider had not provided detail about how they would meet some of the conditions within the DoLS authorisations. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected on 12 April 2016, we found sufficient actions been taken to meet legal requirements. Where people had DoLS authorisations in place, details were present in the care records. None of the authorisations we looked at were subject to any conditions.

People told us that staff asked before care was given. One person commented, "The staff are always polite and ask us before doing things and we are well looked after."

We found further improvements were required to ensure there was written evidence of people's consent or best interest decisions about their care and treatment. For example, some people had sensor mats by their beds. These were to alert staff when people stepped onto the mat. The mats were in place with the aim of reducing people's risks of falls. There was no record of discussions taking place with the person. There was no record of best interest meetings haven taken place with relatives when the person was unable to give their consent. Senior staff told us that discussions had taken place and people or their representatives had agreed to have the mats in place for their safety. The outcome of the discussions had not always been recorded.

The provider's action plan confirmed that staff had received additional training with regard to the Mental Capacity Act (2005) and DoLS. The manager told us further training was required to fully embed the learning from the training into the practices within the care home.

Requires Improvement

Is the service responsive?

Our findings

When we inspected Woodland Grove on 15 September 2015 we found care was not personalised, care plans had been reviewed but were not always updated and did not always reflect people's individual needs. These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected Woodland Grove on 12 April 2016, we found improvements had been made.

The people we spoke with told us they were happy with the care and support they received from staff. One person commented, "They are really nice staff and they treat us well." Another person told us, "I am usually able to dress myself but sometimes I need a little bit of help and they are always willing to help me."

All care plans contained completed 'My Living Story' documents, which provided detail about the person's history, family, career and what was important to them. However, details from the documents were not always incorporated into the care plans to make the plans person centred.

The staff we spoke with, including the agency staff clearly knew the needs of the people they were caring for. The records did not provide sufficient and updated detail of the care people needed to meet individual needs and preferences.

A senior manager told us they had acted on these shortfalls and review meetings had taken place with people and their relatives where appropriate, within the last three months. We discussed the most recent update to the provider's action plan, with the senior managers. They told us progress had been made, and more detail was being recorded. They acknowledged that the care records still needed more detail to make sure people's current individual needs, preferences and choices were reflected.

One person was being cared for in bed. We noted music playing quietly in their bedroom, and staff told us the person enjoyed this type of music. However, their care plan stated their personal care requirements in a task orientated way. For example, "Mouth care" was written. There were no further details about how the person was assisted with this care. We were later told by staff the person was assisted to brush their teeth. This was not recorded. The person's communication needs stated, "Reassurance, speak slowly." In another part of the person's care plan, an entry stated, "Two hourly turns and two hourly safety checks." We noted their call bell was not to hand and staff told us the person was not able to use it. This was not recorded. The staff we spoke with clearly knew the needs of this person.

We saw in one plan where staff had documented the person's emotional needs. It was written that the person liked to be greeted by name and a smile. It was also written in the care plan, 'Likes to have hand held, makes her feel at ease" and "Feels comfortable when someone with her.'

The provider's action plan stated that all personal plans had been updated and reviewed each month. We saw evidence that people's relatives, where appropriate had been invited to attend review meetings at the

care home. Reminders for each person's planned monthly review dates were detailed on a chart in the care office.

One person was described in their care records as sometimes, 'Confused and agitated' and 'Can become loud and agitated.' The care plan provided guidance for staff to, 'Reassure that things are alright' and 'If still agitated, leave for a little while and then go back to see if settled'. The records showed the person sometimes shouted, and showed physical aggression and threatening behaviour towards staff and other people living in the home. The guidance to reassure or leave for a while was not detailed enough and did not provide the guidance staff may need to meet the person's needs or how to keep other people safe. Staff were able to describe how they provided support to this person. They told us they had received on-line training.

We found sufficient action had been taken to meet this legal requirement.

However, we found that accurate records were not maintained and this was a repeated breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

When we inspected Woodland Grove on 15 September 2015 we found the provider had not ensured governance systems were robust to assess, monitor and mitigate the risks to people using the service. Accurate, complete and contemporaneous records in respect of each service user had not been maintained.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected the Woodland Grove on 12 April 2016 we found some improvements had been made. However, insufficient action had been taken to meet legal requirements.

The home did not have a registered manager in post. The current manager who had been in post for three weeks had submitted an application for registration with the Commission.

We were provided with a copy of the provider's updated action plan. The senior managers told us the action plan sent to us following the last inspection had been updated each month. Most actions were recorded as completed. For example, the actions to address the issue, "Personal plans do not reflect customer needs" were stated as "Complete personal plan reviews ensuring all personal plans are updated and reviewed monthly." These actions were recorded as completed on 30 March 2016. However, although most plans had been reviewed and updated, they still did not always reflect customer needs. This meant that accurate records were not maintained for each person.

The senior managers showed us the audit and monitoring systems they had in place. These included systems to monitor the delivery and recording of care on a daily, monthly and weekly basis. However, the system had not identified some of the issues we found and noted in this report with regard to people's care records and monitoring charts. Records for some people's food and fluid intake were not consistently accurate and this placed people at risk. The provider's daily team leader checklist provided prompts for checking monitoring charts. However, these had not been consistently completed.

Staff did not always report issues that may affect people's safety and well-being. For example, we saw ants around the floor and sink area in one person's bedroom. We spoke with a member of staff who told us they had first seen the ants two or three days prior to our visit. They had forgotten to report their observations to senior staff or the maintenance team. The documented room spot checks completed by senior staff had not identified this issue. We reported this to the management team. They told us they would take immediate action to address the issue.

The above were repeated breaches of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We did receive positive comments about the new manager in post. Staff told us they thought the manager was approachable. The manager told us they were committed to improving the quality of the service. One

member of staff commented, "She (the manager) is really approachable and things are changing for the better. Six months ago I wouldn't have brought my Mum here but I would now."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care was not always delivered and in line with people's assessed risks and changing needs. Regulation 12 (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor quality and safety were not always effective. Accurate, complete and contemporaneous records in respect of each service user had not been maintained. Regulation 17 (2) (b) and 17 (2) (c)