St. Martin's Care Limited

Woodside Grange Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Woodside Grange Care Home on14 and 28 April 2016. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting. The inspection was completed because 15 people had raised concerns about the safety of the staffing levels at the home.

At the last inspection on 5, 11, and 20 August 2015 we judged Woodside Grange Care Home to be rated as good but found that action was needed to ensure the systems for overseeing the service were effective and identified risks.

Woodside Grange Care Home is a purpose built care home for up to 121 people, which provides nursing and personal care for both older people with dementia and younger people with mental health needs. There are three floors to the building, each connected by two vertical passenger lifts. All bedrooms are lockable, spacious single rooms, with en-suite facilities. The building is surrounded with private grounds and has on site car parking facilities.

The home has not had a registered manager in post since June 2015. 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 the last inspection in August 2015 the registered provider had employed a new manager and they had submitted an application to become the registered manager on 11 February 2016 but this was not progressed as they left the service in March 2016. At the time of the inspection a new manager had been appointed and had been working at the home for a couple of weeks. To date the new manager has not submitted an application to be the registered manager.

Not having a registered manager is a breach of the provider's registration conditions and we are dealing this matter with outside of the inspection process.

At the last inspection it was found that albeit the provider had systems for monitoring and assessing the service, these had failed to identify that staff were working in silos so not using the resources effectively. It was unclear as to what systematic oversight was given to the nursing service. At this inspection we found these issues remained and we again found staff were working in silos and we could not how the services in the new part of the building were monitored.

At this inspection we focused on the deployment of night staff as concerns had been raised. We found that for 96 people who used the service up until 9pm there were 12 staff members on duty and overnight there were 11 staff members.

The Maple Suite which is for Dementia nursing is staffed with one nurse and two care staff, at the time of the

inspection there were 14 residents. The Sycamore Suite had one staff member on duty as at the time of the inspection there were 8 people living on the suite. Staff told us they could ask for assistance off the Maple Suite but normally found the staff were unable to provide assistance. Of the other residential suites each are staffed by two staff. Chestnut Suite which is for people with learning disabilities is staffed by two and nine people used this unit.

As found at the last inspection the staff worked as individual teams operating into each unit, which meant that staff could be working on their own with over 8 people to support. We found that many people had complex needs and the staffing levels overnight failed to ensure their needs could be met in a timely fashion.

The management team told us that the registered provider had developed a new dependency tool and they were using this to determine staffing levels. Although we asked the manager for information about how and who had developed it, the guidance for staff to follow and the underpinning mechanism for calculating the staffing levels this was not provided. In light of this lack of information we analysed the dependency rating scores and overall staffing calculation against documents showing the each person's details and the dependency levels rated by the placing team and rotas the manager had supplied.

We found the individual dependency assessment concentrated on people's physical ability. The tool did not take into account social inclusion or supporting people to deal with distress. Also the way the questions were worded favoured staff concluding that individuals who used the service were rated as having a low dependency level. The home accepts people with complex needs; younger adults with learning disabilities as well as people who required nursing care however the management team provided no information to demonstrate how this was factored into the tool.

When we compared the assessment the staff had reached with that supplied for each person we found it did not match the dependency levels and was significantly lower than the rating on peoples' information form. We found that the ratings staff arrived at did not match the assessment made by the placing authorities; minimised dependency levels and did not reflect people's actual needs. Using this tool we found it would be virtually impossible to rate anyone at high or very high level needs. Yet people who used the service did have very high level needs and were receiving one-to-one support because of their needs. This had led to insufficient numbers of staff being deployed at the home.

From the information supplied it was extremely difficult to establish how staffing levels were calculated and we were left unable to determine why staffing levels were set at the figures on the sheet. The staff could not explain how they used the tool to calculate the number of staff needed for the whole home or each unit. Although asked for, the registered provider did not supply any information to demonstrate how their tool had been created or checked to confirm it was accurate.

We saw that the some of the people who used the service had more complex needs and even though an additional 31 people were using the service the tool had determined that less staff were needed now than in August 2015. The management team could not explain why this was the case.

We found the provider was breaching one of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the staffing. You can see what action we took at the back of the full version of this 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 safe.

There was insufficient skilled and experienced staff on duty to meet people's needs. The processes in place for determining how many staff should be on duty were flawed.

The registered provider failed to ensure that staff were effectively deployed across the home meaning staff worked in separate units and not as a team.

Woodside Grange 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

An adult social care inspector completed the inspection on 14 and 28 April 2016. Each visit was completed in the evening. Around six hours were spent on site and we also spoke with people outside of the visits.

Before the inspection we reviewed all the information we held about the home including that received from 15 complainants and information from safeguarding meetings. Over two visits we met and spoke with 16 people who used the service and two relatives. We also spoke with the manager, two deputy managers, head of care, two nurses, four senior care and nine care staff.

We spent time with people in the communal areas and observed how staff interacted and supported individuals. On the first occasion we spent 45 minutes talking to people whilst trying to locate staff. On both occasions the vast majority of older people were already in bed but we spent time speaking with the people who were up and the people on Chestnut Suite.

At the first visit we reviewed and took copies of the rotas .We also asked for an extensive range of information about the operation of the home both at our first visit and before we revisited. This included underpinning guidance for the dependency tool and where it was sourced from; detailed information about the people who use the service, including their health conditions, how many staff they need to support them: any episodes of aggression; information about the actions the registered provider has taken to reduce the potential for safeguarding incidents re-occurring and review of any deaths; the last five months falls and incident analysis and associated action plans; last five provider visit reports; good practice guidance you are following in relation to the care of people with learning disabilities, dementia, and general health care and

evidence of how this has been disseminated to the staff; guidance issued to staff around activities, person-centred care and social inclusion; information of the monitoring of this guidance and any assessment of the success of these initiatives; staff training matrix for all of the staff; outline of the training given around specific care and support needs; details of the training staff have had to deal with behaviours that challenge; supporting evidence to show that agency nurses receive an induction to the home; monitoring information around the service meeting the care needs of people using the service.

When we returned we received some of the information and we used this when forming our judgment. This information included the full detailed report for service users, three months analysis of falls and incidents, the rotas for April 2016; dependency tool and rating, the lone working and challenging behaviour policies, guidance for implementing valuing people initiatives and the training matrix. However no information was provided about the people's health conditions and risks, the staffing tool name and associated policy, guidance for staff on completion or how the calculations were completed; or the monitoring information around the service meeting people's needs.

We looked around the service and went into some people's bedrooms (with their permission) and the communal areas.

Requires Improvement

Is the service safe?

Our findings

Fifteen people contacted us to share concerns about the staffing levels and told us that the staffing levels were too low and put people at risk. We asked people who used the service what they thought about the home and staff. People told us that they liked living at the home but found it difficult to find staff at night. People said, "The staff are very good but few and far between in the evening. They have to spread themselves thinly."

At the last inspection we reviewed the dependency tool, we found this to be extremely difficult to use and were left unable to determine how staffing levels were calculated. The staff could not explain how they used the tool to calculate the number of staff needed for the whole home or each unit. At that time there had been 65 people using the service and overnight there was one nurse, two senior care staff and nine care staff. We found that the staff did not work as a team and told us they did not contact staff on different floors or units if they needed support. We found this pattern of working in isolation meant there was insufficient staff on the ground floor residential unit to meet the individual's needs. At this inspection we found the same issues continued and staff still did not work as a team.

At this inspection we found that for 96 people who used the service up until 9pm there were 12 staff members on duty and overnight there were 11 staff members. The Maple Suite which is for Dementia nursing is staffed with one nurse and two care staff, at the time of the inspection there were 14 residents. The Sycamore Suite had one staff member on duty as at the time of the inspection there were 8 people living on the suite. Staff told us they could ask for assistance off the Maple Suite but normally found the staff were unable to provide assistance. Of the other residential suites each are staffed by two staff and the learning Chestnut Suite which is for people with learning disabilities is staffed by two and nine people used this unit. The staff told us that they as a team for individual units, which meant that staff on some units could be working on their own with over 8 people to support.

The management team told us that the registered provider had developed a new dependency tool and they were using this to determine staffing levels. Although we asked the manager for information about how and who had developed it, the guidance for staff to follow and the underpinning mechanism for calculating the staffing levels this was not provided. In light of this lack of information we analysed the dependency rating scores and overall staffing calculation against documents showing the each person's details and the dependency levels rated by the placing team and rotas the manager had supplied.

We found the individual dependency assessment concentrated on people's physical ability. The tool did not take into account of social inclusion or supporting people to deal with distress. Also the way the questions were worded favoured staff concluding that individuals who used the service were rated as having a low dependency level. The home accepts people with complex needs; younger adults with learning disabilities as well as people who required nursing care however the management team provided no information to demonstrate how this was factored into the tool.

In addition to this the staff on each unit completed the tool independently. This lead to staff comparing the

group of people on their unit and determining the more able on their unit were rated as having low dependency levels. The home accepts people with complex needs; younger adults with learning disabilities as well as people who required nursing care however the management team provided no information to demonstrate how this was factored into the tool.

The analysis we completed showed that the full resident details report rated 40 people as high risk and ten people as low risk with the remaining being assessed as at medium risk. The rating dated 19 April 2016 found 25 people on the residential and dementia care unit were low risk, 11 were medium risk and seven were high risk. Staff in the new building told us that when they rated people they had found that one person was high risk and the majority of the other people were rated as low risk. We were provided with no information to suggest the registered provider had reviewed the tool to determine its accuracy. The staff shared concerns that the tool even rated people who were receiving one-to-one support as low risk.

We found that the ratings staff arrived at did not match the assessment made by the placing authorities; minimised dependency levels and did not reflect people's actual needs. Using this tool we found it would be virtually impossible to determine that anyone had high or very high level needs; yet people did have very high level needs and were funded to receive one-to-one support.

We found that the analysis the registered provider completed of accidents and incidents the analysis did not consider staffing levels just actions to be taken in relation to individuals. We were provided with no evidence to demonstrate that the registered provider took action to monitor the tool and confirm it was accurate.

We found that many people had complex needs and from our observations, conversations with the people who used the service and relatives and staff as well as our analysis of the information the staff provided us the staffing levels overnight failed to ensure their needs could be met in a timely fashion.

It was notable that the tool had determined that less staff were needed now than in August 2015 yet the home had an additional 31 people using the service. The management team could not explain why this was the case and we saw that some of the people who used the service had more complex needs. We would have expected that additional staff would be needed to ensure the needs of these extra 31 people could be met.

We found the tool was not fit for purpose and this had led to insufficient numbers of staff being deployed at the home.

This was a breach of Regulation 18(1) (Staffing), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that personal protective equipment (PPE) was not always available on nightshift and staff explained to us they found it ran out frequently. They told us this had been raised with the new manager and felt this matter would be rectified.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed at the home. Regulation 18 (1)