

# J Davies and Mrs S Shroff

# Woodlands

## Inspection report

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### Ratings

#### Overall rating for this service

Requires Improvement



Is the service safe?

Good



Is the service effective?

Requires Improvement



Is the service caring?

Requires Improvement



Is the service responsive?

Requires Improvement



Is the service well-led?

Requires Improvement



### Overall summary

The inspection took place on the 2 and 4 March 2015 and was unannounced. At our last inspection on the 4 April 2013 the regulations we inspected were met.

Woodlands is registered to provide accommodation and support for 19 older adults with dementia. On the day of our inspection there were 19 people living in the home and there was a registered manager in post. 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.

People we spoke with told us they felt safe living in the home and relatives confirmed they had no concerns with people's safety. We found that people were happy and staff knew what actions to take where they had concerns about people being kept safe from harm.

# Summary of findings

We found that the provider did not have the appropriate systems in place to ensure staff received support through regular supervisions, staff meetings and regular up to date training. Training records showed that staff were not receiving training regularly to ensure their skills and knowledge was kept up to date.

We found that the provider was not meeting the requirements of the Mental Capacity Act 2005. Staff we spoke with were not sufficiently knowledgeable to ensure where people lacked capacity their human rights would be protected. The provider also took no appropriate action to ensure where people lacked capacity an appropriate assessment was done and advice taken from the supervisory body as to whether people were being restricted and a Deprivation of Liberty Safeguard application was needed.

People told us that the meals were good and they enjoyed them, but they did not get a choice of meals. Our observations were that the menu was not displayed in a way to support people to make choices and it was not clear how people were involved in deciding the menu options.

We found that people were not always being encouraged to make decisions about the support they got. People

told us how they decided daily when they got up and went to bed and the clothes they wore. But it was unclear how they participated in other elements of the running of the home, through meetings or other forums.

The provider did not take sufficient action to ensure people's privacy and dignity was respected at all times. We found that bedroom doors did not all lock to offer people privacy and bedroom doors on the top floor of the home had glass panels which allowed people no privacy or dignity. The registered manager told us action would be taken to ensure people views and consent was sort as to how their privacy and dignity would be respected in the future. This would include the glass panels being covered.

The provider had systems in place so people were able to give their views by way of completing a questionnaire. We found no recorded evidence to show that people views were being sought through this process and how the information gained was being used to make improvements to the quality of the service provided.

We found that the provider's assessment and care planning records did not accurately reflect people's assessed needs and how they were being met consistently. This meant new staff would not know from people's records what their needs were or how to meet them.

# 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?

We found that the service was safe.

People told us they felt safe within the service.

Staff knew how to keep people safe and the appropriate guidance was in place.

We found that there were enough staff to keep people safe.

Good



### Is the service effective?

We found that some areas of the service were not effective.

We found that staff were not being supported through regular supervisions, staff meetings and training to keep their skills and knowledge up to date so they could meet people's care needs.

We found that staff did not have the appropriate training in the mental capacity act or the deprivation of liberty safeguarding, to ensure they had the information, skills or knowledge required so people's liberty was not being restricted.

We found that people were not able to make a choice as to the meal they had.

Requires Improvement



### Is the service caring?

We found that some areas of the service were not caring.

People told us that staff were caring and kind. Our observations were that the service was compassionate and supportive to needs of people.

People told us that their dignity and privacy was respected by staff, however the environment needed to be improved so that people's privacy and dignity could be consistently met.

Requires Improvement



### Is the service responsive?

We found that some areas of the service were not responsive.

We found that accurate care records were not in place to show how people's care needs were to be met.

We found that people were not consistently able to get regular mental stimulation as part of their preferences or interests. Where people's preferences were being met, it was not recorded as part of the care planning process.

People and relatives told us they were able to speak with the manager whenever they had a concern. We found that the provider had no system in place so people could share their views on a regular basis about the service they received.

Requires Improvement



# Summary of findings

## Is the service well-led?

We found that some areas of the service were not well led.

People and relatives told us the home was well led.

We found that there was a registered manager in post and the environment of the home was homely and friendly.

We found that the provider did not have sufficient records to show how the service quality was being monitored, or how people's care needs were being assessed and delivered.

**Requires Improvement**



# Woodlands

## 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.

Our inspection took place on 2 and 4 March 2015 and was unannounced. The inspection was conducted by one inspector.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

To plan our inspection we reviewed information we held about the home, this included notifications received from the provider about deaths, accidents/incidents, safeguarding alerts which they are required to send us by law.

On the day of our inspection there were 19 people living in the home, only three people were able to speak with us. The other 16 were unable to share their views verbally due to their communication needs so we observed how they were supported. We spoke with the three people who were able to share their views with us, three members of staff and the registered manager who is also the owner of the home. We looked at the care records for three people, the recruitment and training records for three members of staff and records used for the management of the service; for example, staff duty rosters, accident records and records used for auditing the quality of the service. After the inspection visit we undertook telephone calls to three relatives.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not communicate with us.

# Is the service safe?

## Our findings

The people we spoke with told us that they felt safe living within the home. One person said, “I do feel safe absolutely”. One relative said, “They [staff] do a great job in keeping people safe, [relative’s name] can be aggressive due to their illness”. Our observations were that people were being cared for and supported in a safe manner. The staff we spoke with were able to explain the actions they would take if people were at risk of harm. They were also able to give examples of how people could be put at risk and examples of abuse. They told us they received training in recognising abuse and the records we saw confirmed this. The provider had a safeguarding procedure in place to identify to staff the actions they should take to keep people safe from harm.

We found that risk assessments were being completed to identify the appropriate actions to reduce any potential risks to people. We saw that manual handling, fire safety, health and safety and general risk assessments that had been completed. Staff we spoke with had an understanding of the risks they had to be aware of in ensuring people were kept safe.

People and relatives we spoke with all told us there was sufficient staff to meet people’s care needs. One person said, “When I need staff to support me they always support me how and when I want”. Relatives we spoke with told us there was always enough staff when they visited the home. One member of the staff team we spoke with said, “There is enough staff but on occasions sickness is not covered”. Our observations were that there was sufficient staff to support people appropriately. When people needed support staff were seen to support them promptly.

People we spoke with told us that they had no concerns with staff administering their medicines. One person said, “I do get my medicine at the right time”. The staff who administered medicines told us they were not able to administer medicines until they had been trained. Records we saw confirmed this. However, we found that some staff had not had any refreshment in their medicine training for

two or more years. Their competency was not being checked regularly to ensure people’s safety and that staff were still competent to administer medicines. We discussed our findings with the registered manager who confirmed immediate action would be taken to set up training for staff that had not had up to date training, and a system put in place to check staff competency more regularly. This would ensure that staff had up to date skills and knowledge to administer medicines.

Prior to our inspections a number of concerns were raised with us about medicines not being administered appropriately. We found no evidence to substantiate the concerns raised. People we spoke with all told us their medicines were always on time and records we saw confirmed this. We found that the provider had a medicines procedure in place, this incorporated appropriate directions as to how staff should order and dispose of medicines. We found that medicines were being recorded on a Medicines Administration Record (MAR) once people’s medicines had been administered. Where people needed medicines ‘as and when required’ there was a process in place for staff to follow. We found that where people refused their medicines that staff would try to administer their medicines at a later time or record that the medicine had been refused based upon the prescription requirements. We found that medicines were stored and secured appropriately following the standard guidelines for medicine management.

Records showed that the provider had a system in place to ensure that appropriate staff were recruited and checks carried out as part of their recruitment process. Staff we spoke with told us that before they were appointed into the job they were required to complete a Disclosure and Barring Service (DBS) check. This check was carried out as part of the legal requirements to ensure staff were suitable to work with people and any potential risk of harm could be reduced. Staff also confirmed that two references were requested by the provider. Records we saw confirmed this was being done. We found that a declaration process was not in place to ensure staff suitability to work with people could be continually checked as an on going requirement.

# Is the service effective?

## Our findings

We found that staff were not all provided with training in the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS). Staff we spoke with told us they were provided with training but were unable to explain the MCA or DoLS and the implications for people who lacked capacity. One member of the staff we spoke with told us they had not had any training. We found that staff did not have the skills and knowledge required to ensure people who lacked capacity were not being restricted unlawfully. Where staff had received training, this had not been updated for some time. We found that there were no systems in place to determine people's capacity levels. Where people lacked capacity the provider did not make the appropriate contact with the supervisory body to seek clarity as to whether a DoLS application was required. We saw that the provider had a locked door policy within the home and we observed people who lacked capacity were at potential risk of being restricted inappropriately.

We found that where people lacked capacity the provider was unable to show evidence that people were able to give consent before support was given by staff. We observed staff asking people for consent, but there was no evidence to show that people understood what they were consenting to. One person said, "My consent is always given before staff help me". We found where people had capacity their consent was being sought. Records we saw did not always show written consent.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. This meant that the provider had not followed the requirements of the DoLS. Arrangements in place did not ensure that the provider had taken steps to ensure the legislation was appropriately applied and people's rights upheld.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff knew how to support them. One relative said, "I do think the staff have the right skills to

support [relative's name]", another relative said, "Not all the staff work to the same standard to support [relative's name]". We found from the staff we spoke with confusion as to whether they received regular supervision, staff meetings and appraisals. Records did not confirm that supervision and staff meetings were taking place and being used by the provider as a mechanism for ensuring staff had the right support and knowledge to support people to the appropriate standards. We found staff did not all get an appraisal consistently. We raised our concerns with the registered manager who confirmed our findings and told us action would be taken to ensure staff had the right support.

We found that staff had access to training. However the training was not consistent or regular. We found examples of some staff who had not had training for a number of years. While there was a programme of mandatory training requirements, for example training in manual handling, food hygiene and dementia. Not all staff had gone through the required training to ensure they had the appropriate knowledge and skills.

We found before staff supported people they went through an induction process, which involved staff shadowing a more experienced member of staff before they supported people. Staff we spoke with confirmed this.

People told us that the meals were very good. One person said, "I enjoy the meals. I decide what I eat". We saw that a menu was in place so people could make a choice as to the meal they had. However, the menu had not been revised for a number of years and was not visible to everyone in the home. We saw no evidence of the menu being available in formats that made it easy for people to understand the meal choices. One person told us they were able to get alternative meals if they did not like what was on offer. Another person told us they did not get a choice of meal. They were just given a meal. Our observations at meal times were that people generally all had the same meal and there was not a visible choice being offered. Where people lacked capacity it was also unclear as to how they made a choice as to the meal they had. Records did not show people's dietary likes or dislikes. People, who needed support and encouragement, were able to get this support from staff. Staff were very proactive in ensuring people were supported during meal times. People were seen talking amongst themselves and with staff and generally enjoying their meal. Our observations were that people

## Is the service effective?

were able to get regular hot and cold drinks. This ensured they would not dehydrate. People were spoke with confirmed they were able to get drinks whenever they wanted.

Records showed that people's nutritional needs were being monitored and assessed on a regular basis, along with other vital health checks. Where this monitoring raised concerns the appropriate advice or action could then be sought from other health care professionals. Relatives we

spoke with told us that they were kept up to date about people's health care needs and where there were concerns the home always took action. We were told that people were able to see a doctor when they needed, visit the hospital, see a dentist or chiropodist. Records we saw confirmed people were able to see health care professionals when needed. However, we found that the records kept when people saw a health care professional were not always consistent.



# Is the service caring?

## Our findings

One person said, “Staff are lovely, caring and kind. They are always professional”. The relatives we spoke with all felt the staff were caring. One relative told us that staff were always talking with their relative when they visited the home, and they were always happy. We saw that people smiled and were relaxed and contented in the company of staff. No one was anxious when staff were around them and staff came across as caring and concerned for people’s wellbeing.

The people we spoke with told us they were able to share their views on all aspects of their care. One person said, “I decide what I wear and when I get up and go to bed”. We found that even though people told us they were able to share their views about the care they received, there were no record of how people made other decisions that may affect how the home plans activities or decide on matters that affect the home rather than individuals care needs. For example, what the meals menu should include. The registered manager told us that relative meetings did not take place which could involve people. The registered manager confirmed this would be something that would be explored with people and relatives.

We found that people who lacked capacity had less involvement; however staff explained how people were involved in their care. Staff explained that people decided on the clothes they wore, but they were supported to make choices in their best interest. For example wearing a cardigan on a cold winter’s morning, so they could be kept warm. We saw that people were dressed in suitable clothing for the time of year and their age group. One relative did share concerns as on occasions they had found that their relative had not had their hair done and had not

been dressed suitably. On the day of our inspection the hair dresser had been in the home all morning, and people were all seen having their hair styled how they wanted. Other relatives we spoke with were happy with the quality of care to their relatives.

We found that where people were able to support themselves they were encouraged to do so. One person said, “Staff only help me with what I cannot do. I wash and dress myself and staff only do the parts I cannot reach”. We observed someone being supported to walk very slowly using a walking aid, so they were able to keep as much independence as they could, rather than being pushed in a wheelchair. We spoke to the person who confirmed they wanted to walk and keep as much of their independence as possible.

People told us their dignity and privacy were respected. One person said, “On occasions people do wonder into my room”. We found that not all bedrooms had a facility to lock the door and some bedroom doors had a large glass panel. This did not allow for privacy and dignity to be respected. Where this was the case the registered manager did not take the appropriate action to ensure people’s dignity and privacy would be respected. We raised our concerns with the registered manager, who told us that not all people wanted the facility to be able to lock their bedroom doors. The registered manager was unable to provide evidence to show this, and confirmed that people’s consent would be gained as to whether they wanted their bedroom doors locked. Where this was the case it would be made available. The registered manager also confirmed that where bedroom doors had glass panels this would be rectified to give people full privacy and dignity.

# Is the service responsive?

## Our findings

The people we spoke with were unable to confirm whether they were involved in an assessment process. They were also unable to clarify if they were involved in drafting their care plan. Relatives we spoke with did not remember being involved in the care planning process. Records showed that an assessment process was carried out, but it was not sufficient to identify what people's needs were. The documentation used was also not consistent. On one person's records we saw a one sheet document and others we saw a two page document. The process did not allow for the provider to have a comprehensive view of people's needs.

We found that the care plan process was also inconsistent and not effective. It did not allow for the provider to be able to show how people's support needs were being met or a person centred approach to care. For example, one person's care plan document did not have anything about the support the person needed and how this would be provided. It was not written in a person centred way. People we spoke with told us the support they needed was being provided. Relatives told us their family member was receiving the support they needed. Staff we spoke with had a good understanding of the needs of people. We were unable to evidence this from the records we saw.

One person said, "I love a glass of wine, and I am able to have one when I want". They also told us they went out at least three times per week with their relatives. The person then showed us where they kept their bottles of wine.

Records we looked at did not show the person's preference for a daily glass of wine or going out with relatives. Other records also did not show any preferences, like or dislikes for anyone. People told us there were activities provided on an afternoon. One relative said, "I have seen activities going on, but staff don't sit and talk to people". Another relative told us their family member loves to knit, but they are not able to. This was due to staff not having the time to sit and support them. We saw no evidence of any activities apart from the hairdresser who was there when we arrived. People were seen sitting in the lounge sleeping or just sitting looking at the television, which was just left on with little or no planned stimulation. Staff told us there was a book with a three week program of activities. We found that people were not involved in deciding what activities were provided, and where people had preferences this was not taken into consideration when activities were being planned or decided.

One person said, "I was given a copy of the complaints process". They confirmed they knew who to complain too, and told us they would speak with the manager. Relatives we spoke with did not remember being given a copy of the complaints process, but told us they had never had to make a complaint. They confirmed they would speak to the manager if they had a complaint. We found that a complaints process was available. Record showed there had not been a recent complaint, but the registered manager had a process in place to monitor trends as a way of improving the service people received, if and when a complaint was received.

# Is the service well-led?

## Our findings

We found that there was a registered manager who was also a part owner of the home. We found that the atmosphere in the home was relaxed, friendly and homely. We found that the registered manager was constantly around supporting staff to meet people's needs as part of the care team. People and relatives told us that manager was always visible within the home, supporting people and cooking meals. Staff we spoke with confirmed this. People, relatives and staff all felt the home was well run by the manager.

We found that there was a deputy manager in post to cover the home when the manager was unavailable. Staff we spoke with knew the management structure and who was in charge of the home on any given occasion.

We found where decisions needed to be made on a daily basis this could be done without the need for lengthy delays. This meant where there were implications for people's support these decisions could be taken quickly so there was little impact on people's care.

We found that the provider had a whistleblowing policy in place to enable staff to raise concerns they may have with the service people received anonymously. Staff we spoke with knew about the policy and its purpose to enable staff to raise concerns about how people were being or where there maybe potential risk to people.

The provider had an accident and incident procedure in place so staff had clear guidelines as to how such situations should be handled. Staff we spoke with were able to explain the actions they would take where an accident happened and that they would complete an accident book to allow for any trends to be monitored. We found that the registered manager had records to show how this was being done.

We found that the provider's record system was not effective to ensure people's needs were met appropriately. The provider's recording of people's assessed needs and how their needs would be met by way of a care plan was not effective or consistent. For example, people's assessed

needs were not being recorded accurately and care plans did not show how not always show how people's needs would be met. This meant there was a risk that people would not get the support they needed.

We found that the provider had a quality assurance process in place, to enable them to gather views on the service provided to people. One person said, "I have not had a questionnaire to complete". Relatives told us that questionnaires were sent to them to be completed on the service people received. We found that people were not consistently sharing their views and staff were also not part of the process. Records confirmed this and the registered manager told us the information gathered was used to make improvements to the service people received. We saw no evidence to show how improvements were being made, there was no action plan in place.

We found no audits being carried out by the registered manager to monitor the quality of the service provided. We found where there were maintenance work to be carried out there was no records to show how this was being managed or checked to see that it was done.

We found that the provider did not return their completed Provider Information Return (PIR) as we had requested. We were informed by the registered manager that the form was not received as they were in the process of changing their broadband provider. The registered manager confirmed they would inform us of their new email address once everything was set up. We found that there had been no recently notifiable events to us; we discussed with registered manager the legal requirement to notify use of any deaths, accidents, or situations where people were put at risk of harm.

The registered manager told us that audits were carried out on the quality of service. We found that medicines audits were being done, but there was a lack of consistency as to evidence of other audits being done. We were unable to see effective records for example building checks and cleaning rotas to name just two. We found that window restrictors were not being used effectively on every window, which potentially put people at risk of falling from an open window. The registered manager told us that this would be dealt with immediately.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where legal requirements 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	<p>Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>The provider had failed to ensure that an effective system was in place to prevent people being unnecessarily deprived of their liberty.</p>