Wotton Rise Nursing Home Limited

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Wotton House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home can accommodate 27 people in one adapted building; 25 people were living there when we visited.

The home provided permanent accommodation and care to people, but also provided shorter-term accommodation and care to people waiting for further social or health care assessment following discharge from hospital. It provided care and treatment to those who were recovering from surgery and to those who lived with dementia and mental health needs.

People were provided with single bedrooms with washing facilities; there was one shared bedroom. Additional communal bathrooms, toilets, a dining area and lounge were provided. A small garden area and car parking was available. There was wheelchair access to the building and garden area.
At our last inspection in April 2016 we rated the service as 'Good'. At this inspection we found the evidence continued to support the rating of 'Good' and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection. It met all fundamental standards.

There were two registered managers who shared responsibility for managing the service. A registered manager is a person who has registered with the CQC 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 were kept safe. The premises were well maintained and kept clean. There were enough, suitably recruited and experienced staff to look after people. People's risks were identified, reduced and removed altogether, where possible. People were protected from potential abuse and discrimination; the policies and systems in the service supported this. People were given help to take their medicines safely. Accidents and incidents were monitored and action taken to reduce recurrences. Lessons were learnt from errors and duty of candour was applied.

People had access to health and social care professionals. Staff worked closely with other agencies and services to help support people's use of or transition through different care services. The principles of the Mental Capacity Act and Deprivation of Liberty Safeguards were followed. People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People's nutritional risks were identified and addressed. Staff received training and support to be able to meet people's needs.

Staff were caring. People told us their care was delivered by staff who were kind and compassionate

towards them. Relatives told us they also felt supported and welcomed. People's privacy and dignity was upheld and staff were respectful of people's diverse needs and preferences. Staff adapted the way they communicated with people to meet people's individual communication needs. People's preferences and wishes were respected and met.

People's care was planned and reviewed. Care was planned and reviewed with people's involvement, where possible. People's representatives, where appropriate, were part of this process. People were supported with their social needs and to get involved in activities provided in the home. Managers were currently looking at ways of making activities provision more personalised. A complaints procedure was in place which was followed when any complaint or area of dissatisfaction was expressed. Staff supported people at the end of their lives to have a dignified and comfortable death.

The home was well managed by the two experienced registered managers and a new manager had been recently recruited. It was planned that this manager would eventually register to become the sole registered manager of the home. The two currently registered managers would continue to manage the business under their roles as Directors of the company.

Effective quality monitoring systems were in place. These monitored the performance of the service and quality of care provided. Actions for improvement were identified and completed. This process however, was not always recorded and there was no formal record of on-going improvement actions or when and if these were completed. This was currently managed informally between the two registered managers who were fully aware of who was responsible for what action and who shared their plans for on-going improvement effectively with their staff. This was however, a largely, informal system, which the registered managers were going to review when they started to delegate more responsibility for the management of the home to the new manager. We made a recommendation in relation to the recording of quality monitoring processes and systems.

Both registered managers kept their individual knowledge up to date. They did this by discussing areas of best practice with visiting professionals, by retaining membership of various professional groups and by taking part in local health and adult social care initiatives.

The views of people and their representatives were sought to help improve the services provided to people overall. The feedback provided was reflected on and acted on where it would help improve outcomes for people.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

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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 was a comprehensive inspection which looked at all five key questions Is the service safe, effective, caring, responsive and well led? This inspection took place on 24 and 26 September 2018 and was unannounced. The inspection was completed by one inspector 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. In this case someone who cared for an older person.

Prior to the inspection we reviewed all information we held about the service which included statutory notifications. This is information, forwarded to us, by the provider telling us about events which we must be informed about by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also took into consideration feedback received from commissioners of the service.

During the inspection we gained the views of five people who used the service and five relatives. We spoke with the two registered managers, the new manager, one nurse, one team leader, a cook and four care staff. We reviewed three people's care files which contained risk assessments, care plans and other relevant care records. We also reviewed people's records relating to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

We reviewed three staff recruitment records, the staff duty roster and staff training records. We looked at a selection of audits, checks, staff competency checks and feedback questionnaires, which were part of the

provider's quality monitoring processes. We requested to be forwarded to us and read, the homes policy and procedures on equality and diversity and protocol for escalating [to professionals] information about behaviours which challenge. We reviewed the home's maintenance records and service certificates.

Good

Is the service safe?

Our findings

At our last inspection in April 2016, we rated this key question as 'Good'. At this inspection we continued to find that people remained safe; protected from avoidable harm and potential abuse.

People told us they felt safe. Comments included "I'm safe and sound, looked after well, nice people [staff]. All very good" and "Quite safe, definitely. Not worried at all." Relatives agreed and one relative told us they were "relieved" their relative was now safe. Another relative described their relative as being "Safe and secure". This relative visited on a regular basis and told us they thought this each time they visited.

People were protected from potential abuse and discrimination. They were treated equally and their diverse needs recognised and met. Managers had a zero tolerance of any form of discrimination. Policies and procedures in the home supported this approach. Staff had been trained to recognise potential abuse and report concerns. Notifications from the home showed that managers had reported and shared relevant concerns with other agencies who have responsibilities in safeguarding people.

Risks to people's health were identified and action taken to reduce these or to eliminate them altogether. We reviewed risk assessments which recorded what the risk was, for example, falls, developing pressure ulcers or malnutrition. The level of risk was assessed and relevant care plans gave staff guidance on how to manage these risks and keep people safe. One person said, "The Sisters [nurses] are particularly good, they come in to check my skin for any blemishes."

Environmental risks were managed in the same way. Arrangements were in place to monitor and ensure the safe use of all utilities, the premises and equipment. Safety systems, for example, relating to fire detection, evacuation and the water and heating supply were safely maintained. Contracts were in place with specialist companies to assist with this.

People's needs, in relation to their mental health and associated behaviours were met. Care strategies were developed to reduce risks from, for example, behaviour which could challenge and which could potentially put people and others at risk. Staff consulted with and took advice from, specialist mental health professionals to support people's wellbeing. People who lived with dementia and who experienced anxiety and distress, were provided with appropriate support to help alleviate this. Staff used diversion techniques and sometimes one to one care to improve people's wellbeing. In the case of two people, specialist health care professionals monitored their mental health needs to ensure the care and treatment being provided was appropriate.

People's medicines were administered by staff who were trained and competent to do this. Medicines were stored securely and at the manufacturers' recommended temperatures. We observed staff giving people time to take their medicines. Time sensitive medicines, such as those used in Parkinson's Disease and for pain relief, were administered when they were due. Records were kept of when medicines were administered, delivered and returned to the pharmacy. When asked about their medicines people said, "Lots of pills. Painkillers. All very good. The nurses are good" and "…. tablets morning and night, not sure

what they are for; they [the nurses] have told me."

There were enough staff with appropriate experience and skills to support people's needs. Staff responded swiftly to people's call bells. People in their bedrooms, as well as those in communal rooms received regular checks and interaction from staff. Comments from people, about staffs' ability to be available when they needed help included, "They get to me within minutes" and "I ring the bell and staff get to me quite quickly. Not bad anyway." One person told us they could ring their bell, anytime at night, and the staff respond quickly. A relative said, "There never seems to be a desperate shortage of staff."

Staff were recruited safely. All appropriate checks, including those against police records, as well as appropriate references, had been sought and received back before staff started work. Once recruited, staff completed a probationary period during which they were supported, trained and their progress was monitored.

People lived in a clean home. People confirmed their bedrooms were kept clean. Cleaning staff were employed and managers checked all areas, daily, to ensure sufficient cleaning was carried out. There were arrangements in place to prevent cross-contamination. Staff used protective aprons and gloves when delivering people's personal care and when supporting them with their food. One person told us about the laundry and explained there were always clean clothes for them to put on. There were arrangements in place to manage soiled laundry safely.

Good

Is the service effective?

Our findings

At our last inspection in April 2016, we rated this key question as 'Good'. At this inspection we continued to find that people received care which supported their health needs. People were still supported to make independent decisions.

People's needs were assessed before they were admitted to the home. One relative who had supported their relative in this process said, "They (staff from the home) assessed his needs well. Before coming here, there was a full assessment of [name's] needs and abilities." The registered managers told us, they or another member of staff, always completed a pre-admission assessment. When people were admitted from a distance we were told all possible information about the person's needs was sought beforehand. Registered managers told us this process enabled them to remain confident that they could meet a person's needs once they were admitted.

The home had a high turn-over of people, discharged from the local hospitals, who required further support or assessment from adult social care or health care professionals. The staff had built up good links and working relationships with professionals and commissioners of services so that people could be supported during this transitionary period. There were good processes in place to ensure staff were made aware of people's changing needs and risks and those newly admitted. One newer member of staff and an agency nurse confirmed they were given up to date information about people's needs whenever they were on duty.

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 as far as possible that 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.

We checked to see if the home had continued to adhere to the principles of the MCA. People were supported to make independent choices and decisions and staff supported them in the least restrictive way. Where decisions about people's care and treatment had been made on their behalf this had been done following best interests processes. One person said, "I'm always ask if I would like help, they [staff] never do anything without asking."

The registered managers had assessed people's mental capacity, where appropriate to do so, and, where required, submitted applications to the supervisory body (local county council) for DoLS. Six people had authorised DoLS in place and one person's had conditions attached. These were being adhered to by the staff and reviewed by the supervisory body. Other applications had not yet been processed by the supervisory body. Staff had received training on the MCA and DoLS and understood the principles of the Act.

Staff received training in many other subjects which included for example, safeguarding adults, fire safety, infection control and safe moving and handling. Medicines training was provided to staff who administered medicines. There were arrangements in place to check staffs' competencies in several areas of care delivery.

Additional training had been provided to ensure nurses and care staff were knowledgeable in subjects such as Parkinson's Disease, care planning, clinical observations, pressure ulcer prevention and wound care.

Registered managers had completed more advanced training in, safeguarding adults procedures and managing Legionella risks. One of the registered managers and the new manager had completed a 'dementia lead' course. This enabled them to support best practice in this area of care and to promote better outcomes for this group of people.

Nurses were supported to maintain their registration and re-validation of their registration with the Nursing and Midwifery Council (NMC). People told us the staff knew what they were doing and they were confident of their skills. One person said, "They're very good when they hoist me – very careful" and another person told us how the nurses had improved the health of their legs. They said, "The Sister [a nurse] is very good, knows what to do. My legs are much better now."

People had regular access to health care professionals. One person told us they had seen a physiotherapist since living at the home. Another person told us they saw a chiropodist "every 6 weeks or so." Another said, "I've been seen by the GP a couple of times." This person explained they had to attend hospital appointments and the staff organised the transport for them. Relatives confirmed they had seen or been aware of doctors visiting, blood tests being done, chiropody being provided and a dentist visiting. The registered managers told us local dentists provided NHS dental care which staff supported people to access. One relative told us their relative had been "well supported by in-house nurses, mental health [professionals] and the GP."

People's nutritional risks were identified and managed. People's weight and their appetite were monitored and any concerns referred to their GP. Two relatives spoke with us about the nutritional support their relatives received. One relative told us their relative now required pureed food, which was provided and how their relative had gained weight. Another relative told us their relative's health had declined but how staff supported them with sweet and fortified drinks which their relative liked. Food and drinks were sometimes fortified to provide people with additional calories. Fortification was done by adding ingredients such as full fat powdered milk, cream, butter and cheese to food and drinks.

People with swallowing difficulties were referred to a speech and language therapist (SLT) for assessment. The cooks then prepared people's food in the texture advised by the SLT, for example, pureed or thickened drinks. The cooks could accommodate any dietary need or preference, for example, related to culture or religious belief. They were aware of people's likes and dislikes and provided people with a choice of food and drink. Comments from people about the food included, "We can always get something else, alternatives. It's very good that they do this", "Lovely dinner [today] and they do a good roast" and "It's very good food here. I eat everything put in front of me."

Good

Is the service caring?

Our findings

At our last inspection in April 2016, we rated this key question as 'Good'. At this inspection we continued to find that people were cared for in a caring and compassionate way.

People were given support by staff who we observed to be kind and caring towards them. People's comments included "The staff are all very pleasant. There is never a problem with the staff", "The staff are alright, a good mixture and friendly", "The staff are lovely, kind and really caring" and "I get on well with all of them I like a bit of banter." One relative said, "Lovely kind people [the staff], it's very good care. No complaints on this front at all."

The registered managers told us their recruitment process looked to identify staff who were first and foremost kind, caring and compassionate. They told us other skills could be taught but this could not be and a lack of caring and compassion was not tolerated.

We saw staff smiling at people and leaning forward when they spoke with them, demonstrating they had a real interest in what people had to say. On several occasions, we observed staff putting their arms around people's shoulders and showing genuine affection and empathy towards them. Staff spoke with people in a respectful and unrushed way, giving people time to express themselves. People were relaxed and at ease around the staff and we often heard laughter between them. Staff supported each other and appeared to have a good relationship with each other. This contributed to a calm and happy atmosphere.

People's diverse cultural and religious preferences were explored and supported. One person's cultural preferences were supported by the staff. Although the person was happy to eat western food, they did enjoy and prefer food from their own culture so staff took time to prepare this for them. Another person enjoyed praying with a member of staff from the same faith as them. This member of staff had afforded time and thought in doing this as they knew it was important to this person.

People were aware they had care plans which recorded what care they needed and how it should be provided. They told us the staff had regular conversations with them to establish if they were happy with the care being provided to them and if they needed anymore help. One person said, "We talk about the care plan, I've not seen it, but sister [a nurse] talks about things." Relatives told us they were aware that the care plans were reviewed and that they felt involved in this process. One relative said, "They [staff] keep me informed about her care and we talk about the care plan" and another relative said, "We [staff and them] go through the care plan, there are no problems at all."

Staff ensured people's privacy and dignity was maintained. People who could not do this for themselves looked well dressed and smart. They had their hair combed and attention had been given to their oral hygiene. One relative told us they knew their relative's personal hygiene, "their dignity" as they explained it to us, was met because they checked this when they visited and always found it to be met. People told us their privacy and dignity was respected. Comments included, "They [staff] usually do knock on my door" and 'If I have a bath or shower they [staff] treat me very respectfully." Another person told us, "I like to keep my

door shut, keeps it private."

Good

Is the service responsive?

Our findings

At our last inspection in April 2016, we rated this key question as 'Good'. At this inspection we continued to find that people's care was planned around their needs and they were supported with social activities.

People's care was delivered in a way which met their needs and diverse preferences. We observed one person, who lived with dementia, become distressed. This was responded to quickly and compassionately. Staff demonstrated a genuine desire to help this person regain their wellbeing. They sat with the person and through skilful interaction they moved the person on from their distressing thoughts.

Staff had been concerned about another person's self-isolation and repetitive calling out when the person was in their bedroom. This person also lived with dementia and mental health needs. When attempting to support the person to leave their bedroom, the person became overtly distressed. We therefore observed staff visiting this person, in their bedroom, on a regular basis, to not only deliver aspects of care but to also interact with them when the person was able to accept this.

Another person who lived with dementia had begun to call out at night time, showing signs of continuous distress. By working with this person's relatives and the relatives of another person who lived with dementia, this person started to share a bedroom. We were told both had appeared to be aware of each other's presence and the calling out stopped. One of the relatives told us their relative's privacy and dignity was always maintained. This was done during delivery of personal care by staff pulling across the privacy curtain which hung in the bedroom.

People and their representatives were involved in the planning of their care. We reviewed three people's care files which contained numerous health assessments and risk assessments. Care plans had been formulated around the information from these assessments and from what staff had found out about people's life history and preferences. Although when talking with staff they knew how to meet people's individual needs, care plans, in relation to behaviours which could challenge, lacked detailed guidance for staff. We discussed this with the registered managers who had been aware of a countywide initiative which supported personalised care planning for people who lived with dementia and challenging behaviours. By the second day of the inspection personalised care planning had been formulated, using the format from the initiative. We saw this in place for the support given to two people with these needs. The registered managers told us this format would continue to be used.

The provider adhered to their complaints policy and procedures. There were arrangements in place for people, their relatives and other visitors to the home, to raise a complaint or express an area of dissatisfaction if needed. Two relatives told us they had raised areas of concern and these had been sorted out immediately. They confirmed they had not been worried by these concerns since. Another relative told us they had been given the home's complaints procedure but had not needed to use it to date. The home's complaints file contained records of what complaints had been received and how and when these had been acknowledged, managed and responded to. We reviewed records which showed investigations of complaints had taken place and whether the complaint had been substantiated or not. The final response

to the complainant was also recorded. Where the process of reflection was useful to help make improvements or prevent a similar complaint, this had been completed.

People were supported to take part in social activities or one to one activities which supported their wellbeing. Comments from people about this included "There are entertainers, singers, and exercise things going on", "Staff do come in for a chat. I prefer not to join in with things, I prefer to read and watch the TV" and "I like the things going on."

A new member of staff had been recently employed and they had been given designated hours per week to support people's activities. They, along with the new manager, were due to attend a countywide forum for activities and wellbeing. This provided support and a network for staff who acted as a lead in activity provision in their service. We observed care staff supporting people to take part in a bingo session, singing and an arts and crafts activity. Staff told us a range of activities were organised which included, musical events with external entertainers, gardening, cookery, quizzes and games.

One registered manager told us how they planned to personalise the activity provision further. As part of their 'dementia lead' course they had looked at the benefits of personalised and meaningful activities on people who lived with dementia. During the inspection we observed that this approach was already in place for some people and was making a difference to their levels of engagement and enjoyment. For example, in one person's case staff had gathered information from the person and their relatives about their lifetime interests and hobbies. This person had a particular interest, which staff then incorporated into the activities they supported this person with. This subject was therefore familiar to the person and of interest to them and resulted in the person being able to more meaningfully engage in activities with the staff.

Another person, from a different cultural background, was supported to talk about things which were familiar to them and which evoked good memories by a member of staff who was of the same cultural background. A new member of staff belonged to the same community activity as this person had and was therefore able to introduce familiar, in this case, songs and music, for the person to enjoy and talk about.

Pupils from local schools visited the home at Easter and Christmas and also completed work experience placements at the home. One student did this at weekends and provided social interaction with people which was mutually enjoyed.

People's end of life wishes and preferences were explored with them so staff could be aware of these and meet these at an appropriate time. Any advanced wishes were explored and made known to the staff. Where people lacked mental capacity to make end of life decisions, these were made, in their best interests, by the staff with the person's GP and their representatives. Staff were experienced in supporting people to have a dignified and comfortable end of life. They were also experienced in supporting relatives at this time. There were established links in place with appropriate health care professionals as well as community religious leaders and groups who also supported people's end of life.

Good

Is the service well-led?

Our findings

At our last inspection in April 2016, we rated this key question as 'Good'. At this inspection we continued to find the service to be well managed.

Two registered managers shared the responsibility of ensuring the service was run well. They shared the same vision which was for people to receive safe care from staff who were genuinely caring. These managers had clear expectations on staff behaviour and the values staff should have. Staff were also committed to ensuring the service provided a good service to people and they supported the managers' vision. New staff told us they were aware of the high standards set and they were personally pleased to be part of the overall service.

The registered managers were highly visible. They worked closely with their staff and helped them when needed to support people. They were fully aware of each person's needs and progress, of individual staffs' performance and the overall staff culture. They had regular informal and formal meetings with staff to ensure good communication was maintained between them and staff and different staff teams. It was also evident that there was good communication between people, relatives and the management team.

We observed the staff to be highly respectful of the registered managers, who we observed in turn, to speak to their staff in a polite and supportive manner. Both registered managers told us they valued their staffs' contribution, their commitment and ideas. Staff were often flexible in the way they worked to ensure the home ran smoothly. In return, the registered managers tried to be as accommodating as possible with the staff, for example, leave requests.

One relative said, "The owner [the registered managers] is very hands on", another said, "If you want to see the management they make time and come and see you straight away" and a further relative said, "It's well managed, you can talk to any of them -senior staff and managers]."

There were processes in place to quality monitor the service and to check if the standard of care delivered to people was good. This was done through a mixture of recorded audits, checks and staff competency checks. Quality monitoring was also completed at an informal level, through the registered managers' and other senior staffs' daily observations and unrecorded monitoring checks. As the registered managers were hands on and involved with the service on a daily basis, information about areas for improvement were mainly discussed and communicated verbally. Actions identified following a recorded audit, were recorded on the audit but a record was not always kept of when these were completed. One registered manager told us this was because things were always addressed "immediately" by either themselves, the other registered manager or whoever they delegated the task to.

The registered managers were aware of current best practice in key areas of care through their links with various professionals and organisations. They were aware of, for example, guidance by the National Institute for Health and Care Excellence (NICE) relating to activity provision and end of life care. The registered managers told us about their plans for on-going improvement in these areas. For example, to introduce end

of life care records for the last days of life and to personalise the activity provision further. These plans and actions were not formally recorded on for example, an action plan.

We discussed the benefits of using a formalised system, which could record proposed actions and which would provide an audit trail, of actions completed and improvements achieved. In particular, we discussed this in relation to when they started to delegate more responsibility to their new manager. Currently, any actions completed by the new manager were checked, informally, by one of the registered managers. A formalised system would help provide the information needed for when the current registered managers were less involved in the day to day management of the home, but still needed to audit the home's performance and ensure planned improvement was being achieved. The registered managers told us they would review their system moving forward.

We recommend that the service seek advice, from a suitable source, about a formalised quality monitoring system, which can assist in providing the evidence needed to demonstrate that appropriate actions are being completed and that these are leading to on-going improvement in the service.

People's views and those of their relatives and others who visited the home were sought as part of the registered managers' quality monitoring process. We reviewed some of the questionnaires returned from the last satisfaction survey. These were all positive without exception. One comment, from a professional, had been made in relation to reviewing a protocol. We requested a copy of this following our visit which showed that a more robust joint working protocol in relation to sharing information with professionals about escalations in challenging behaviours.

There was evidence of effective working in partnership with commissioners and acute care providers to provide a service to people. The registered managers kept abreast of the care needs of the local community and ensured their service was able to support these. For example, this included, the need for day care and the ever-growing demand for adult social care support for people, discharged from hospital but who required further assessment and support.