Mrs I Crosbie

Woodhall Park Nursing Home

Inspection report

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Tel: 0115 949 0444

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
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

This inspection was unannounced and took place on 8 December 2015. The service was registered to provide accommodation for up to 41 people. People who used the service had physical health needs and/or were living with dementia. At the time of our inspection 38 people were using the service.

At our last inspection in December 2013 compliance actions were issued in relation to the need for consent to care and treatment, and the management of medicines. The provider sent us a report in January 2014 explaining the actions they would take to improve. At this inspection, we found improvements had not been made since our last visit regarding consent to care and medicines management. We also found evidence of other regulatory breaches which related to staffing, the Deprivation of Liberty Safeguards (DoLS) and good governance.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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. The provider had recruited two people to manager the service who were jointly registering with us.

People told us there were not enough staff and we observed people's needs were not always met due to the lack of staff availability. Risk assessments were not always up to date or used by staff to support people. We observed medicines were not stored correctly and there was no clear auditing of medicines or their administration.

Staff had been provided with training in a range of skills; however we observed some staff were not competent in the use of equipment. The staff and manager had limited knowledge about ensuring people were able to make decisions about their care and had not completed appropriate assessments to support people's decision making in their best interest . This relates to the Mental Capacity Act 2005 and DoLS. The manager had not consistently completed audits in relation to the quality of care provided, to consider on going improvements to the service.

People told us the staff were kind, although not always responsive to their needs and preferences. There were limited activities within the home, which mainly related to group activities and not focused on people's individual preferences.

People told us they enjoyed the food and they always had a choice from a menu. Special diets were catered for to ensure people's nutritional needs were met. Referrals had been made to the appropriate health professionals to ensure people received the right support in maintaining their wellbeing.

People felt safe within the service and staff knew how to raise a concern and felt confident it would be responded to. The provider had a complaints policy, people and relatives felt able to raise any concerns and records confirmed previous complaints had been dealt with efficiently.

You can see what action we told the provider to take at the back of the full version of the report.

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?

The service was not safe

There were not always sufficient staff to support people with their needs. Medicines were not stored in line with guidance and there were no audits to ensure medicines were administered safely. Risk assessments were not always followed. People felt safe within the home. The provider had a clear recruitment process to enuse the staff employed had received the necessary checks.

Requires improvement

Is the service effective?

The service was not effective

People were not always supported to make decisions and where there was a lack of capacity staff had not followed the requirements under the Mental Capacity Act 2005. Where people had their liberty deprived, the appropriate authorisations had not been applied for. Staff received an induction and training, competency checks had not been completed to ensure staff had understood and were implementing the skills they had learnt. People's food choices were responded to and people were encouraged to maintain a healthy diet. People had access to health care professionals when needed to support their health and wellbeing.

Requires improvement

Is the service caring?

The service was not always caring

People were not always treated with kindness and compassion. Staff had established some relationships, but lacked the skills and knowledge to meet people's needs. Relationships which were important to people were encouraged and supported. People's privacy and dignity was respected.

Requires improvement

Is the service responsive?

The service was not responsive

The care plans did not reflect people's individual requirements for their care. The activities were group focused and therefore people's individual hobbies and interests were not reflected in the stimulation available. There was a complaints procedure which was well managed and people's complaints were responded to and addressed.

Requires improvement

Is the service well-led?

The service was not well led

Effective systems were not in place to assess, monitor and improve the quality of care. Staff received varied support and the overall service was not clearly managed. The service did not have a registered manager.

Requires improvement

Woodhall Park Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. Our inspection was unannounced and the team consisted of two inspectors and a specialist advisor in dementia care.

We checked the information we held about the service and the provider. This included notifications that the provider had sent to us about incidents at the service and information we had received from the public. We also spoke with the local authority who provided us with current monitoring information. We used this information to formulate our inspection plan. On this occasion, we had not asked the provider to send us 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. However, we offered the provider the opportunity to share information they felt relevant with us.

We spoke with four people who used the service and five relatives. Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us to assess if people's needs were appropriately met and they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with five members of care staff, the cook and one of the managers. We reviewed four staff files to see how staff were recruited. We looked at the training records to see how staff were trained and supported to deliver care appropriate to meet each person's needs. We looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Requires improvement

Is the service safe?

Our findings

We saw there was not enough staff. During the inspection one person had a fall and we had to locate a staff member to attend to the person as there were no staff available in the lounge. People told us there was not enough staff to support their needs. One person said, "There is not enough staff they are run off their feet." A relative we spoke with told us, "There is not enough staff, especially at weekends." We observed several occasions when there were no staff to support people's needs. For example, we heard one person requested to go to the bathroom, staff did not hear the request as there were no staff in the lounge area. We saw the person waited for over an hour after their initial request The person was supported when they took the person to attend the hairdresser. We saw people were transferred in wheelchairs, when they were taken into the lounge area we observed they were not offered the option to be transferred into a comfortable seat. We observed this support was only offered following these concerns being discussed with manager.

All the staff we spoke with said staff numbers have not increased in line with the needs of the people who used the service. Staff told us they felt unable to provide the personalised care and it was task focused. One staff member said, "We don't get time to spend with people, it's very busy." The provider did not use a dependency tool to reflect the numbers of staff required to support people. A dependency tool provides guidance on the numbers of staff in relation to the number of people at the service, their needs and the layout of the building. This meant the provider was not ensuring the correct staff support was available to meet people's needs.

This evidence demonstrates a breach of the HSCA Act 2008 (Regulated Activities) Regulations 2014 Regulation 18

There was concern for the safe storage of the medicines. For example the medicine trolley was locked, however we saw antibiotics remained on the top of the trolley and the trolley was in an area accessible to people. We observed the main medicines room being unattended whilst the door was propped open. Within this area we saw oxygen cylinders stored incorrectly and with the nasal pipe still attached.

We observed the breakfast medicines round had not been completed until 11.10am, and the lunch medicines started at 12.50pm. This meant the gap between morning medicines and lunch time medicines was for some people very short. The provider did not have a system in place to ensure the correct gap between medicines was in place. This meant we could not be assured that people received their medicines as prescribed. We observed a further time delay in the lunchtime administration of the medicines and we saw the nurse being interrupted on several occasions during the medicine round, this had the potential for mistakes to be made.

This evidence demonstrates a breach of the HSCA Act 2008 (Regulated Activities) Regulations 2014 Regulation 12

People had risk assessments in place which related to the various elements of the person's care. We saw some of these had been reviewed on a monthly basis but some did not reflect the care being provided to people. For example one risk assessment stated the person was not to be positioned on their right side; however the daily entry notes showed the person had been placed regularly on their right side. Another risk assessment identified the piece of equipment required to transfer the person. We observed a different piece of equipment being used and staff expressing confusion as to which piece of equipment was correct for that person's transfer needs.

We saw the provider had a recruitment process in place to ensure pre-employment checks had been undertaken. This identified staff were of good character and nursing staff had the qualifications, skills and experience necessary, including registration with the nursing and midwifery council. Records confirmed that the checks had been completed prior to employment which include a Disclosure and Baring Service (DBS) number. A DBS is a criminal records check, completed to ensure the person had not had any previous criminal convictions. One staff member told us, "I completed my DBS before I started work." This showed the provider had taken steps to ensure the staff were suitable to work with people.

People told us they felt safe. One person said, "The staff here make me feel safe." A relative we spoke with told us, "I have no reason to be concerned, [name] is safe." Staff were aware of what constituted abuse and knew how to report any concerns. Staff told us. "If I see something that I think is not right I will report it to the manager or the local

Requires improvement

Is the service safe?

authority." Staff told us about the information in the reception area on the noticeboard which showed a poster about safeguarding and how to report concerns, this was available for anyone to use. This showed the provider had supported people's safety.

Requires improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) legislation sets out the requirements, when people lack the mental capacity, to ensure that decisions about their health, safety and welfare, are made in their best interest. At our last inspection in December 2013 we found there was a breach of Regulation 18 of the Health and Social Care Act (HCSA) 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 11 of the HSCA (Regulated Activities) 2014. At this inspection we saw the provider was still not fully complying with the requirements of the MCA and DoLS.

We saw a DoLS application had been refused by the local authority. The home had not considered any further assessments or support in relation to the person's deprived liberty. There were other people who exhibited a wish not to remain within the home, however an application had not been made for them or documentation to consider how they are managing the person's expressed wishes. The manager and staff we spoke with had limited understanding of MCA and the DoLS legislation and were unable to clarify the scope of the Act and how it impacted on their responsibilities in supporting people's liberties. This meant the provider was not responding appropriately to people's deprived liberties.

This evidence demonstrates a continued breach of the HSCA Act 2008 (Regulated Activities) Regulations 2014 Regulation 13.

The MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack capacity to take particular decisions, any made on their behalf must be in their best interests and least restrictive as possible. The mental capacity assessments we saw did not provide information about the level of people's mental capacity or demonstrate how specific decisions were made for them. For example, some people required bedrails to reduce the risk of them falling from their bed. Where people lacked the mental capacity to make this decision for themselves a best interest assessment had not been completed. Where relatives had been asked for their permission, this was not documented to confirm that the person had giving their permission. We observed staff didn't always give people a choice or ask the person for their permission before supporting them. For example, one person expressed a wish not to sit on a pressure cushion; the staff member dismissed the request and placed the person on the cushion without an explanation of why the cushion was in use. Another staff member told us this person usually remains in their wheelchair, no explanation was provided to the person why they were being moved. This demonstrated that the staff did not have respect for people's wishes and decisions about their care.

This evidence demonstrates a breach of the HSCA Act 2008 (Regulated Activities) Regulations 2014 Regulation 11.

Although records and staff confirmed they had received training we observed that staff were not confident in the use of the equipment when transferring people. For example, we observed whilst a person was being transferred, their knee was caught on the main bar of the equipment. Little guidance or verbal support was offered to provide assurance to the person during the transfer. We also observed an unsafe transfer when staff were unable to use the equipment due to the person's position. The staff said, "[Name] is so crammed I cannot see what I am doing." We saw there was no competency assessments completed following staff induction to clarify the staff were competent in using the equipment. We saw that some staff did not respond to people with an understanding relating to their illness. For example staff did not respond to people who kept repeating requests or offer explanations to assist the person's understanding. Staff we spoke with confirmed they had not received training on dementia or behaviours that challenge. The manager was not able to tell us how many people using the service had a dementia diagnosis and had not considered the need for training to support staff to meet these people's needs. This demonstrated that the provider was not ensuring the staff were trained to support people's needs both for safety and for their needs relating to living with dementia.

People told us the food was good and they always received a choice. One person said, "The food is always acceptable." A relative we spoke with told us, "The food is good, [name] gets a choice, they even pureed a full English breakfast." We observed the lunch time meal and saw there was a choice and specialist diets were catered for with people's allergies noted. There was a four weekly menu plan which was designed following consultation with people that used the

Requires improvement

Is the service effective?

service. There was a white board showing the written menu for the day, the manager told us they were planning to introduce a pictorial menu to support people with their choices.

Referrals had been made to health professionals to maintain people's wellbeing. We saw that all referrals and any required actions had been recorded in the care records. For example one person was recorded as having weight loss; the healthcare professional had requested a three day diary be completed. The service had completed the diary and emailed the results to the healthcare professional. Relatives we spoke with told us, they were kept up to date with their relatives changing needs and any appointments or healthcare professional visits.

Requires improvement

Is the service caring?

Our findings

We observed staff passed people without any acknowledgement and we heard some comments which were not reflective of a personal approach. For example a staff member pushed a person in a wheelchair into the lounge and said, "Can I park this here?" Another comment we heard was, "[Name} just give it a rest." People told us staff were mostly caring. One person said, "Most are caring, one or two are a bit abrupt." The majority of interactions we observed between people related to the completion of a task and was not centred around the individual.

Whilst most staff seemed caring in nature there was at times a lack of attention to detail when caring for people. For example one person had loose dentures. This person was observed on three occasions with their dentures falling from their mouth. We observed some staff passed this person without offering support.

Relatives we spoke with told us they were able to visit the service whenever they wished. The home has a keypad entry into the home and relatives had this number so they could come and go as they wished. The service had a link with the local church, on a Sunday people were supported to the church service if they wanted to go and the 'friends of the church' brought them back.

The manager was aware of the advocacy service and how to make a referral. Some people had previously accessed this support; however at the time of the inspection no one was using this service. An advocacy service can be provided to people offering free advice, guidance and assistance in raising concerns and acting on people's behalf if they wished.

People we spoke with felt staff respected their privacy and dignity. One person said, "They always knock on my door and provide my personal care in my room." A relative said, "[Name] is always well presented with clothes which are coordinated." We observed during the mealtime when a person became unwell, a screen was placed around the person whilst the paramedics attended to them.

Requires improvement

Is the service responsive?

Our findings

The care plans we looked at did not consider people's life history and their individual preferences to care and support. Staff told us they had started to complete 'life history books' with people, the books which had been completed had not been used to reflect the person's preferences to their care plan and they were stored in a separate location to the main care records. For example staff were unable to tell us about people's life and their interests, staff we spoke with reflected on the care task of a person, not the individual and their interests or hobbies.

The provider was not always responsive to people's needs. We observed people requesting support, which was not provided either swiftly or in line with their request. For example one person had requested a cardigan, which was not responded to and the person did not receive this item. Another person requested a cup of tea; they were offered a glass of lemonade. The person expressed their displeasure at the lemonade and did not receive their tea until the trolley came around some time later.

We did not observe people being supported with social activities. The notice board showed some big events planned and relatives we spoke with said there had been some activities for the season. The provider had no plan of stimulation which related to individual's preferences. The provider's questionnaire identified the need for more stimulation. One relative commented, 'There is not a proactive culture to encourage social interaction.' Another comment said, 'There is little evidence of social activities.' The manager confirmed there was no action plan in place to follow up the comments from these questionnaires. This demonstrated that the provider had not responded to people's requests or provided regular hobbies and interests.

People told us they felt able to complain and were confident it would be responded to. One person told us, "I have had no need to complain." A relative we spoke with said, "I have had one or two niggles, these have been remedied quickly." Other relatives told us they were aware of how to complain and felt any concerns would be dealt with efficiently. The manager told us, "We don't have problems, we can resolve things, people are encouraged to speak to the manager straight away." The provider had a complaints policy and we saw that complaints that had been received had been responded to in line with their policy. This showed the provider had a system in place to support and respond to complaints.

Requires improvement

Is the service well-led?

Our findings

The service did not have a registered manager. The provider had employed two people to provide the management support to the service. The manager's process to register with us had been started over six months ago, however due to the incorrect completion of the process the managers would have to restart the process. At the inspection they told us they had not yet restarted this process.

There was a mixed reaction to the support staff received, staff told us they felt supported by one of the managers. One staff member said, "Fantastic support, any qualms you can go to [Name]."However other staff comments said, "[Name] is not always approachable." This showed a disjointed approach to the support offered to staff. One manager told us the two managers met to discuss the service. There were no minutes or action plans relating to these meetings or the development of the service. The provider met with the two managers when requested, these were not planned meetings and no record was kept of the actions of these meetings. This meant the provider was not taking overall responsibility to ensure the managers were running the home in meeting people's needs and staff support, through planned meetings.

We saw the last recorded medicines audit had been completed over three months ago and raised some concerns in relation to medicine administration and the stock numbers. No follow up audit had been completed to confirm if these elements had been resolved. We saw a medicines complaint in relation to the dispensing of medicines did not instigate an audit check of the processes or staff competencies.

People and relatives had received a questionnaire, it raised some concerns in relation to the limited activities and some areas received either satisfactory or below satisfactory. There was no action plan to reflect how this would be responded to or how any changes would be communicated back to people. The manager told us they had not yet audited the questionnaires or considered any action plan; the questionnaires had been completed four months previously.

We had a number of concerns about the lack of quality assurance processes in the home to monitor the service provision. We saw that care plans were not always reviewed and did not reflect the care that was provided. For example the care plan of one person who preferred to remain in their room did not reflect this or identify the safety checks to ensure the person did not become isolated. Staff confirmed the person chose to remain within their room and that they provided two hourly checks. The daily log showed checks had been made, not always at regular intervals, often the checks were linked to a task or meal. This meant the care records did not reflect the practice or support staff with guidance on the person's needs.

Staff told us and records confirmed they had not received a group staff meeting. Staff we spoke with felt the meetings were an opportunity for the manager to cascade information about the service. The manager told us some staff had received a meeting; there was no documentation to confirm the meeting had taken place or the content of the meeting. Staff did not always understand their roles and responsibilities. For example we saw one staff member asking for direction, 'Should I be supporting in the dining area?' During the lunchtime we observed there was no clear system to ensure people had received their meal and we saw some people were left waiting for over an hour.

The home was supporting people who were living with dementia; they had not considered any dementia environmental support. For example there was no signage in relation to places or directional guidance to support people to be independent within the home. This showed the provider had not considered the environmental needs for the people using the service.

This evidence demonstrates a breach of the HSCA Act 2008 (Regulated Activities) Regulations 2014 Regulation 17.

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	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Consent to care was not sought in line with legislation and guidance. This meant people could not be assured that decisions were being made in their best interest when they were unable to make decisions themselves.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks to people's health and wellbeing were not consistently identified, managed and reviewed.People's medicines were not managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People were not supported to ensure their own safety and assessments had not been requested from the local authority under the Deprivation of Liberty Safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Effective systems were not in place to assess, monitor and improve quality of care. People were not engaged in

This section is primarily information for the provider

Action we have told the provider to take

sharing their opinions about the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider's legal responsibilities had not been met regarding statutory notifications that are required in accordance with the regulations.