HC-One Limited

Washington Lodge Nursing Home

Inspection report

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Date of inspection visit: To Be Confirmed
Date of publication: 10/09/2015

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

Washington Lodge Nursing Home provides nursing care for older people, some of whom are living with dementia. It also provides care for people with mental health conditions. It is registered to provide care for 65 people. At the time of our visit there were 30 people living at the home, with a further two currently in hospital.

The last inspection was carried out in December 2014 where we identified a breach in regulation 15 in relation to the premises. We completed a visit in June 2015 and confirmed all improvements had been made.

This inspection took place over two days. The first visit on 29 July 2015 was an evening visit and was unannounced

Summary of findings

and which meant the provider and staff did not know we were coming. Another visit was made on 30 July 2015, whereby we visited the service early morning and for the remainder of the day.

The home had a registered manager in place. 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.

During this inspection we found the provider had breached a number of regulations. We found capacity assessments had not always been carried out and obtaining consent to care and treatment did not always reflect current legislation. We noted that care plans and risk assessments did not always reflect people's current needs and in some circumstances were over a year out of date and people's needs and abilities had greatly changed. We also noted that where the registered manager had identified areas that needed to be improved there was no action plan or clear structure on how this was going to be done.

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

People and their relatives told us they thought the care provided at the home was safe and people were well cared for. One relative we spoke to said, "The staff know her well and notice changes in her moods." One person we spoke to said, "This is one of the best places I've lived."

We saw the home had systems in place for medicines administration. The medication administration records that we reviewed were up to date and there was no gaps in recording. We saw a signature chart was not available on one floor. The staff member administering the medicines advised they would ensure a copy was made available.

Staff we spoke to were comfortable about what to look out for when working with vulnerable adults, they were confident in the safeguarding procedure and said they would speak up if they had any concerns.

The provider had a staffing tool which used the dependency of the residents in the home and any consideration of incidents to calculate a staffing ratio. The registered manager told us if they had any concerns then they could make a request to override the staffing level.

People told us they enjoyed the food that was provided. We saw menus were clearly on display and offered a number of meal time choices.

Staff had not always received the appropriate level of training, supervision and appraisal for their competencies to be assessed.

The complaints policy was clearly displayed and where complaints had been received they were clearly recorded and responded too. The provider told us about the advocacy support they provided and we saw this also advertised in the service user guide.

The provider had a clear auditing timetable and we saw the health and safety audits were thorough and clearly recorded. Not all audits had picked up areas of concern identified during our inspection.

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?

Requires improvement

The service was not always safe.

There was a clear system in place for safe administration of medicines. The home also had weekly and monthly audits to identify any discrepancies.

Although improvements had been made to the cleanliness and smell in the corridors we noted a number of bedroom carpets were dirty and bins in the bathroom were not peddle operated to prevent infection.

Suitable numbers of staff were available at all times. The registered manager told us they could increase the staffing levels if they felt the staffing tool was not correct.

Is the service effective?

Requires improvement

The service was not always effective.

Capacity assessments were not always carried out. Policies and procedures for obtaining consent to care and treatment did not always reflect current legislation and guidance and were not always followed.

Staff had not always received the appropriate level of training, supervision and appraisal for their competencies to be assessed.

People told us they enjoyed the food and we saw that their needs and preferences were accommodated.

Referrals had been made to specialists when people's assessed needs had changed.

Is the service caring?

Requires improvement

The service was not always caring.

Our observations during the visits were not always consistent. Although we observed some good practice we noticed not all staff spoke to people and offered choice.

People told us they liked living at the home and felt they were well cared for.

The home advertised advocacy support for people who could not always speak for themselves.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care plans were out of date and did not reflect people's individual needs.

Summary of findings

Although an activities timetable was available we noted limited stimulation throughout the home and a lot of people were watching TV or were in their room for the full period of our visit.

The home's complaints procedure was clearly advertised and we saw all complaints were investigated and responded to appropriately.

Is the service well-led?

Requires improvement

The service was not always well-led.

Where improvements had been identified we saw that no clear action plan was in place to limit risk or identify when the actions would be complete.

We saw the home had a good staff team who worked well together and were supported by the registered manager.

The provider had a system in place for regular audits and we saw most of these were completed and provided a thorough check on the quality of the service.

Washington Lodge 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.

This inspection took place over two days. The first visit on 29 July 2015 was an evening visit and was unannounced which meant the provider and staff did not know we were coming. Another visit was made on 30 July 2015, whereby we visited the service early morning and for the remainder of the day.

The inspection team consisted of four adult social care inspectors, a specialist adviser and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed information about any incidents we held about the home. We contacted the commissioners of the relevant local authorities before the inspection visit to gain their views of the service provided at this home.

During the inspection we spoke with 11 people living at the home and seven relatives. We also spoke with the registered manager, regional manager, two nurses, six care staff, an activity staff member and a chef. We observed care and support in the communal areas and looked around the premises. We viewed a range of records about people's care and how the home was managed. These included the care records of eight people, the recruitment records of three staff members, training records and quality monitoring reports.

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

Requires improvement

Is the service safe?

Our findings

People and their relatives told us they felt people were safe, however their views regarding the cleanliness and general safety of the home were sometimes mixed in response. One relative said, "The staff know her well and notice changes in her moods." Another relative pointed out a bedroom floor to us and said, "This floor has needed vacuuming all week."

We spoke to the registered manager about the premises. She told us historically they had an issue with some odours in the corridors but they were trialling a new steam cleaner which seemed to have helped with this. During our inspection we noted the home was clean, however some bedrooms were untidy with unmade beds or debris on the carpets.

We saw that a number of the bathrooms did not have pedal operated bins to prevent the spread of infection and although a number of the pull cords for lights had plastic coating, we saw they were only partially covered so not all areas of the cord were able to wipe clean.

The registered manager told us all safeguarding incidents were recorded on the provider's electronic system. Each safeguarding incident was reported appropriately and a summary of action taken was detailed. Staff we spoke to told us they were confident on reporting any abuse.

We observed the medicines round and saw that staff were clear in relation to the reason for each medicine and ensured the person gave permission before administration. For example, when giving pain relief to one person we saw the staff member explain what it was for and check the person was happy to receive it.

We looked at medicines administration records (MAR) for six people using the service. We found an individual profile and photograph were in place at the beginning of the MAR chart, however some people's records did not have anything recorded under allergies therefore it was unclear if they had none or whether this had been an omission when completing the MAR.

We saw a signature list was available on one floor but not the other. The nurse we spoke to advised that she would arrange for this to be put in place. The MARs we viewed showed no gaps or discrepancies. We saw a daily drug check was complete for five residents, we saw these audits picked up no discrepancies. In addition we saw a monthly audit was completed.

PRN medicines were recorded on the MAR but also had a separate instruction sheet available. One staff member we spoke to told us the procedure for if a person refused their medicines, this included contacting the GP if it was refused for a three day period. They were clear of individual drugs where they would notify sooner, such as warfarin.

We saw that accident and incidents were recorded thoroughly and analysed for any learning. We noted that due to the information recorded the registered manager had set up a falls meeting following on from the trends identified.

Risk Assessments were completed individually for people within the home based upon their needs. We saw people had detailed risk assessments for falls and moving and handling. For example, one person's risk assessment detailed how if they were constipated they leaned to the side which put them at a greater risk of falls. The registered manager advised they were aware however that a number of the risk assessments needed to be reviewed as they had not been done for a number of a months and an audit had recognised they did not always reflect people's current needs.

We reviewed five staff recruitment files. We found the provider had requested and received references including one from their most recent employment. A disclosure and barring service (DBS) check, previously known as criminal records bureau (CRB) checks, had been carried out before confirming any staff appointments.

We noted the home had a staffing tool to calculate the staffing levels, the registered manager told us it was all done electronically but they added in people's dependency and any incidents and the staffing ratio was calculated. They explained if they thought more consideration was needed on the results of the dependency tool or more staff then they could submit a report to be considered. Despite the staffing tool available the registered manager told us the basic staffing ratio was one staff member to four residents but they explained this could change depending

Requires improvement

Is the service safe?

upon the needs of the residents. They continued to say the usual staffing levels were seven care assistants, two nurses, one activity coordinator, one chef, one kitchen assistant and two domestic staff.

We reviewed the rota for the week of our inspection and the following two weeks and noted the staffing levels were as described. During our two days at the home we saw call bells were responded to promptly and staff were clearly visible throughout the home. One relatives we spoke to told us they thought there should be more staff on duty, however all other relatives and people told us they thought there were sufficient staff to keep people safe however they did not always get to know them. They said, “We don’t get to know the staff, they come and go.”

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and to report on what we find.

Staff were expected to complete a training course called, 'Understanding the Mental Capacity Act and DoLS' but we noted that 23 staff had late or expired training. One member of staff told us, "I had some MCA/DoLS training, I think about 5 years ago". Another said they had, "No formal training on MCA but have had other training."

The registered manager told us, "27 haven't got capacity" but we were not shown evidence that capacity assessments had been undertaken. Some care plans made reference to such assessments, but there was no detail on the decision the person was unable to take, what practicable steps had been taken to help them make such decisions and whether less restrictive options had been considered. The registered manager told us they were, "Working through assessing them" at the rate of "four a week." Where assessments were carried out, we noted that the provider's policy was not always followed. For example, one person was assessed without consultation with their family which resulted in a formal complaint being made. This was investigated and an apology was issued.

We were shown five DoLS applications that had been granted and were told that the provider had, "loads of them to put in." People were not given the door code to the home and were not free to leave. This could amount to a restriction under deprivation of liberty safeguards. We asked what would happen if people who had not been assessed as lacking capacity asked for the door code. One member of staff told us, "I think I wouldn't give the door code as it is not safe or in their best interests". Another said, "We'd try to stop [people]. We're compelled to. When you have a longer term therapeutic relationship with people you get to recognise people and can make decisions in their best interest."

This may be a breach of people's human rights as without relevant best interest decisions and capacity assessments preventing people from leaving may form a restriction to people's liberty.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that some people had Lasting Powers of Attorney (LPA) referenced in their care plans, but there was no documentation to confirm their status. A lasting power of attorney is a legally appointed position, whereby one or more people are appointed to support a person to make decisions or to make decisions on their behalf. The registered manager told us that the provider was in the process of writing to people's families for evidence of their status.

Staff were required to successfully complete induction training as a condition of their employment. We were shown a training compliance summary. This showed that staff received mandatory training in 'Emergency Procedures, Fire Drills, Food Safety in Care, In Safe Hands – Health and Safety, Infection Control, Manual Handling, Safeguarding, Safer People Handling and Understanding Equality and Diversity'. The provider monitored completion of the training, and we noted that their most recent audit showed that '84.7%' of required training had been completed.

The registered manager told us that she was working on increasing this to 100%, but we were not shown a training matrix. We noted the provider also monitored when current training was due to expire so that staff could be assigned courses before their training expired.

There was a matrix that showed when supervisions had taken place, but when we looked at supervision records they were often identical for all staff. For example, 14 supervisions took place on 16 July 2015 and the content of the supervision record was identical for each, no feedback from staff was recorded and no training or support needs were identified.

There was no matrix to show when appraisals had taken place or were planned. Only 3 people had received appraisals in 2015. The registered manager told us, "All supposed to have been done by the end of August and all of the nurses by tomorrow [30 July 2015]." One member of staff told us, "The door is always open if there are things we want to discuss."

We carried out observations in the dining rooms, and saw that meals were well-presented and looked appetising. One person told us, "The food is nice here." Menus were clearly displayed and contained allergy and nutritional information about the dishes on offer. Though the provider used a set menu, people were free to order whatever they

Requires improvement

Is the service effective?

wanted. We saw that one person wanted sandwiches instead of the meal on offer, and these were provided. People could have as much food as they wanted. For example, we saw that one person ordered two dishes at breakfast. The provider also had two snack stations at the home, which provided a selection of sweets, biscuits and juice. There were also three water stations throughout the home, though we noted there were no cups available for use at these.

We spoke to the chef, who was knowledgeable about people's nutritional and support needs. For example, the evening meal on offer came in regular, fork mashable and pureed options and desserts were planned to maximise nutritional intake. We saw that people were given appropriate support to eat, both in the dining rooms and in their rooms. Where care plans referred to a support need we saw that this was accommodated. For example, one person required a pureed diet and we saw that this was provided. People at risk of malnutrition were weighed monthly and staff had a working knowledge of who required additional support. For example, when a person asked for a drink, we saw that staff recognised that this should be fortified in line with their care plan.

We saw that the 'Resident Guide', which was publically displayed, contained information on external services available to people, such as podiatrists, opticians and dentists. The registered manager told us that people made use of such services. We saw that care plans contained evidence of referrals to external professionals such as the Speech and Language Therapy team (SALT) and general practitioners.

Requires improvement

Is the service caring?

Our findings

People we spoke to told us they felt well cared for in the home. One person said, “Staff put sunshine in my life.” And, “Sometimes they care for me too much.” Another person said, “This is one of the best places I have lived.”

On arrival we spoke to the registered manager who was clearly knowledgeable about people’s behaviours, about what might trigger their behaviour or what signs to look out for, particularly in cases where residents’ behaviour may challenge others.

Throughout our visits we saw that staff always knocked on people’s doors before entering and always waited for a response. We observed four meals during our inspection and saw staff offered people support in a caring and respectful way that respected their dignity and independence. However, we did note that everyone wore an ‘apron’ during the meal time experience. We observed this wasn’t always a choice, that staff said “here’s yours”, rather than giving people the choice. During one meal time we noted one person say, “Oh I take it I have to have one as well.” We observed the staff member did not respond or check this was okay; instead they placed an apron on the person.

We observed the staff relationships with people living at the home were varied, although all staff were polite in their interaction. We saw some staff members were very talkative and engaged in conversation with people and got people talking about things, such as activities, meals, what they would like to do. However, we observed other staff members who appeared to be task driven and did not communicate as much with people, either for reassurance or for stimulation.

During one period of observation we noted one person trying to walk out of the dining room with a hot cup of tea, we observed two different staff members try and distract the person by talking to them or offering them a seat or explaining their lunch was on their way. However we noted a third staff member took the cup of tea out of the persons hand without any explanation. Although the person did not appear to be bothered by this interaction we concluded it did not add any value or build any relationships for the person.

The registered manager showed us how they had set up two ‘tea rooms’ within the home, one on each floor. We saw they were catered with tea and coffee making facilities and the tables were laid out for afternoon tea. They told us the rooms could be used for activities but were also available for relatives and visitors if they wanted to have meals with people or just want some privacy to sit over a cup of tea without interruption.

One relative told us how the staff welcomed them into the home. They said, “On Sundays they let me have lunch with him in the tea room.” They continued to say, “I can’t praise them enough, the quality of care is so good.”

One relative told us they didn’t feel they or their relatives were always involved in decisions. They explained how their relative had moved rooms a number of times and this had been done without consultation. On reviewing some of the care plan audits we noted there was areas for action around evidencing resident and relatives input.

Another relative we spoke to could not praise the home more. They explained their relative had lived there for four months and were impressed by how well the staff dealt with what could be very challenging behaviour. They continued to say, “The care in my eyes is outstanding. I can leave happy and that’s outstanding for me. My mam has a different diagnosis to everyone here and they are amazing with her. ”

The registered manager told us that no one at the home currently had an advocate supporting them. However we saw the resident guide advertised advocacy support and made reference to the number of external agencies that could support a person if an advocate was required.

Requires improvement

Is the service responsive?

Our findings

On reviewing some of the care records we saw there were a number of care plans and risk assessments that were out of date and therefore did not reflect the current needs of the person. For example, we noted one person's care plan referred to them being prone to wandering and requiring finger foods to help maintain their independence. However, during our observations we noted this person was now supported in a specialist chair and was unable to feed themselves. We saw another person who was on a pureed diet; however this was not clearly identifiable within their care plan.

We saw one person's care plan described the need to administer covert medication. On speaking to the staff we were told this was no longer relevant and did not apply as the person was always happy to take their daily medicines and this had only been an issue when in hospital.

We spoke to the registered manager who told us they had completed an audit of care plans following some feedback from the local safeguarding authority and they were aware that action needed to be completed to ensure the care plans reflected people's individual needs.

We concluded the lack of up to date detail and information in people's care plans meant we could not be sure that people received personalised care that was specific to their individual needs. In addition the lack of guidance about how staff should be supporting people could lead to inconsistencies in care delivery. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

On arrival at the service we saw the activities timetable was displayed clearly in the entrance way to the home, as well as in the corridors both upstairs and downstairs. At the time of our inspection there was four days' worth of activities advertised, these included: afternoon tea, home baking, hairdresser and cheese and wine afternoon. However, we noted limited activities going on within the home. We saw people were either sat in the lounge watching television or in their bedrooms. We noted a lot of the activities available were not always suitable for people living with dementia.

One relative told us how their family member didn't like to leave their room and so the staff had arranged for a party to be brought to their room so they didn't miss out. They continued to say, "My mam is bright as a button and they keep her engaged."

We spoke to the activities coordinator who told us they had been in the role for nine months but were still trying to work out a system. They advised they were trying to record individual activities that took place with each person, however at the time of the inspection these were only available for people on the first floor and the ground floor documentation had not been started.

We were told the activities coordinator was currently organising an external event in a local pub to raise money for the residents and the home. However we noted the planning and running of the event did not involve the residents and therefore in the short term had little impact on preventing social isolation or encouraging stimulation in the home environment.

We recommend the provider and registered manager research meaningful activities for people living with dementia.

The complaints policy and procedure was clearly displayed in the reception and in communal areas of the home. We noted that the service user guide also referred to seeking people's feedback on a regular basis. We saw that it referenced the suggested people that feedback could be provided too, for example care staff and the home manager. It also provided a telephone number, postal and email address for the provider's compliance team for people to provide feedback.

We requested to review the complaints log and at first this was unavailable. The registered manager explained the complaints were all entered onto the provider's electronic system and they were unsure how to access a full log. Later in the inspection we received the complaints log and noted all complaints were accurately recorded. We did however note that as some complaints had been investigated by people outside of Washington Lodge, for example regional managers, this meant the full detail of the complaint and the statements taken were not available to evidence the decision made. We did however note that outcomes were recorded on the system and analysis could be achieved at provider level on the complaints received and the nature of them.

Requires improvement

Is the service well-led?

Our findings

The provider had a calendar of audits that were required from each home. These included care plan audits and health and safety audits. We reviewed the health and safety audits and documentation from the registered managers walk around of the building and saw these were done effectively and actions were recorded where needed. The registered manager told us however that until a recent safeguarding incident and the feedback they had received they hadn't completed the care plans audits on the frequency indicated by the provider's schedule.

The registered manager told us they were working through an audit sheet for all care plans. They continued to say, "As some of the care plans are written 2013 and 2014, rather than review them, because they are out of date I'm getting them to rewrite them." We saw that over the two month period since the audits had started 14 residents care plans had been audited and three had since been updated. Where action was required we saw the registered manager had noted a 'changes to be made by' date at the top and marked each as 'urgent'. We saw that some care plans were due to be revised by the beginning of June 2015 but at the time of our inspection were out of date.

We concluded that 11 care plans had been audited and required action to ensure they were up to date and reflected people's individual needs and risks and a further 16 still required audit to assess whether they were suitable and met the needs of people. We noted that no action plan was in place to record the priorities of this work and the agreed timescales.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the home had regular residents and family meetings. We noted the minutes for the meeting on 25 June were available in the communal areas and dates for the remainder of the year were clearly advertised. One relative we spoke to told us they felt the residents meetings needed some work as, "They mainly focused on individual needs."

During our visits we noted the staff team worked well together and supported the people living at the home as a team. For example, during our visit one person took unexpectedly ill during a busy time of day. We saw one staff member was very proactive and coordinated their peers to ensure others were not impacted and important jobs got job. The staff were very receptive to this and we saw good communication which meant the unexpected situation did not impact on other people living in the home and the staff were well organised and shared the work accordingly.

Staff we spoke told us they were happy in their role and felt supported. Two staff members we spoke to told us they felt improvements had been made since the registered manager had started the previous year. We observed the registered manager in practice and noted they worked as a member of the staff team, and supported people in the home as well as the staff. Two relatives we spoke to told us they hadn't really got to speak to the new manager properly yet.

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 17 HSCA (RA) Regulations 2014 Good governance The homes audit procedures did not always identify areas for improvement and where they did clear timescales were not always identified. Regulation 17(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People's care plans did not always reflect their individual care needs. Regulation 9(3)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's capacity to make decisions had not always been clearly assessed and was not specific to tasks or situations Regulation 11(1)(2)(3)