Runwood Homes Limited

Wisden Court

Inspection report

Wisden Road
Stevenage
Hertfordshire
SG1 5JD

Tel: 01438354933
Website: www.runwoodhomes.co.uk

Date of inspection visit:
27 November 2018

Date of publication:
04 January 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

At our last inspection we rated the service good with one area rated a requires improvement. This was in relation to improvement needed for personalised care, care planning and activities. At this inspection we found that the areas which required improvement had been improved however we found that other areas now required improvement.

Wisden Court is a 'care home'. People in care homes receive accommodation and 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.

Wisden Court provides accommodation for up to 54 older people, this included people living with dementia. At the time of the inspection there were 48 people living there.

The service had a manager who was registered with the Care Quality Commission (CQC). 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 and associated Regulations about how the service is run.

People and their relatives were mostly positive about the management team and how the home was run. There were systems in place to help identify issues and address them. However these were not always effective.

People told us that they felt safe and staff knew how to report any concerns. Medicines management needed to be improved to reduce the risk of any medicine errors. Staffing at peak times needed to be reviewed to ensure the deployment of staff helped reduce people waiting. Individual risks were assessed but the whole process needed to be recorded in a more robust way. Infection control was promoted.

People and their relatives were mostly happy with the care they received and people's care plans were personalised. However, there were areas in regards to personalised care and recording in care plans that needed to be improved. Complaints were investigated and responded to. However, management and staff response to these needed to be further developed

Staff were recruited safely and received training and supervision. Staff knew what was expected with them and the service worked with other agencies to help develop systems in the home. The staff worked in accordance with the principles of the Mental Capacity Act.

People enjoyed their meals and maintain a healthy diet and people had access to health professionals. The building was designed in a way that people could move around as they wished and bedrooms were personalised.

People told us that staff were kind and they felt cared for. People were involved in planning their care. Confidentiality was promoted and privacy and dignity was respected and activities planning took into account what people enjoyed.

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 consistently safe.

People told us that they felt safe and staff knew how to report any concerns.

Medicines management needed to be improved.

Staffing at peak times needed to be reviewed to ensure the deployment helped reduce people having to wait.

Individual risks were assessed but the process completed needed to be recorded in a more robust way.

Infection control was promoted.

Staff were recruited safely.

Is the service effective?

Good

The service was effective.

People were supported by staff who were trained and felt supported.

The staff worked in accordance with the principles of the Mental Capacity Act.

People enjoyed their meals and maintained a healthy diet.

People had access to health professionals.

The building was designed in a way that people could move around as they wished.

Is the service caring?

Good

The service was caring.

People told us that staff were kind and they felt cared for.

People were involved in planning their care.

Confidentiality was promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were happy with the care they received. However, feedback from relatives was mixed and our observations found that there were areas of the service that needed to be improved.

People's care plans were personalised. However, we were not sure that these were consistently followed.

Complaints were investigated and responded to.

Activities planning took into account what people enjoyed doing.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People and their relatives were mostly positive about the management team and how the home was run. However, some feedback was mixed.

There were systems in place to help identify issues and address them. However, these were not always effective.

Staff knew what was expected with them.

The service worked with other agencies to help develop systems in the home.

Wisden Court

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We did not request a provider information return (PIR) for this inspection. This is information that the provider is required to send to us, which gives us some key information about the service and tells us what the service does well and any improvements they plan to make.
The inspection was carried out on 27 November 2018. The inspection was unannounced and carried out by two inspectors.

During the inspection we spoke with seven people who used the service, one relative, eight staff members, the deputy manager, the registered manager and the regional manager. We reviewed information from service commissioners and health and social care professionals. We viewed information relating to seven people's care and support. We also reviewed records relating to the management of the service. Following the inspection we received feedback from four relatives.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe. One person said, "I do feel safe here." Relatives also felt people were safe. One relative said, "At Wisden Court I know my [relative] is safe and I can now have a bit of my life back." Staff were aware of what form abuse may take and what to do if they had a concern. We saw that there was information on recognising and reporting abuse displayed in the home. A staff member said, "I am confident to approach the managers and raise issues and I found them to be listening." The registered manager had reported concerns appropriately to the local safeguarding team and also had informed the us.

People had their individual risks assessed and these risks were reviewed monthly. However, where some people were assessed as being at risk, the process taken to mitigate the risks were not always documented. For example, one person was assessed as being at very high risk of developing a pressure ulcer, however, they were not assessed for, or given, a pressure relieving cushion for use when sitting. The staff told us that they could move around independently but the registered manager agreed that the process should have identified the need for a cushion. Another person was at risk of not eating or drinking enough but they did not have their intake monitored, or supplements requested from the GP, despite the person losing weight and the monitoring tool stated the person should be monitored and weekly weights taken. The person was nearing the end of their life and consideration should have been recorded. Also, where another person was noted to be at risk of frequent falls, discussions with the person about how to minimise the reoccurrence whilst not impacting on their independence had not happened. For example, in relation to moving their room around, in order to reduce the risk of falls. We found that the person had been reviewed by their GP and had their medicines changed. Although we found that these issues had not necessarily had an impact on these people, for example, no development of a pressure ulcer, the risk of the impact was there. We discussed these areas with the registered manager who told us that these areas would be addressed immediately. This was an area that required improvement.

Accidents and incidents were reviewed by the registered manager to help ensure all remedial action had been taken to reduce the risk of a reoccurrence. Actions to be completed were displayed in the office to enable them to track progress. A relative told us that their relative had suffered falls and the staff had taken immediate and appropriate action. They said, "I can tell you they are lovely and very caring they have had to call for an ambulance on both occasions and each time [person] is well looked after and I am contacted immediately even if it is not serious, I really appreciate being contacted as I wouldn't not want to know and then I can go and sit with her while she is being assessed."

We noted that there had been an increase in falls during August. The registered manager told us that this was due to a particularly difficult period where they had been short staffed and had used agency staff. We found that these had reduced into September onwards as staffing vacancies had reduced. However, we found that many falls occurred peak times when staffing was reduced due to the time of day and when staff were busy. For example, at night and in the evening and while personal care was being given in the mornings. The management team told us that this would be reviewed and appropriate action taken to address this.

When we arrived on the day of inspection there were four staff supporting 48 people. Although the home is on one level, the layout made it difficult for staff to observe and support everyone who requested support. Staff prioritised personal care which meant people were waiting for drinks and were left unsupervised in communal areas. Some of whom were walking around, at times without their walking aids as they had forgotten to use them.

People told us that their needs were normally met but at times had to wait when staff were busy. One person said, "The call bells are answered but at times it's a waiting time because they are so busy. It's not enough staff." A relative told us, "I know there is a staff shortage and we are mostly there at weekends but I do at times worry about the level of supervision." They went on to say, "We are told that things are being addressed and that some problems down to short staff." Another relative said, "There seems to be a shortage of staff at times, especially at the weekends, and this seems to lead to [person] being left on [their] own for extended periods of time."

Staff told us that in the mornings it was particularly busy. One staff member said, "Sometimes it is enough the three care staff, sometimes we could do with more. We can always call the manager or the deputy even in the middle of the night if there is an emergency." Another staff member said, "For me it's enough staff during the night. It is very busy and we have no time to stop especially when people want to get up. We take our break on the unit so we are still around if people need us." Staff told us that things had settled more lately with staff but at times they were busy. However, the deployment of staff at peak times was an area that required improvement.

There were systems in place to promote safe management of medicines. This included staff training, audits and daily counts of boxed medicines. However, we counted 10 boxed medicines and found that three of these did not tally with records held. For example, one person had the same medicine, but in different doseages, to be issued at the same time. The stronger dose had been issued twice and the smaller dose had not been issued. In all the three instances the daily count had not recognised the discrepancy in quantities. We also found that one trolley, although it was locked, had not been secured to the wall and was kept in a communal area. We discussed this with the management team who told us that they would immediately review the medicines.

Due to issues found with medicines and areas in relation to risk, this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Safe and effective recruitment practices were followed to help make sure that all staff were suitable for working in a care setting. They ensured all required documentation was received before a member of staff began employment.

There were systems in place to help promote infection control. These included cleaning regimes and schedules and training for staff. We saw that staff used gloves and aprons appropriately and the home had no malodours on the day of our inspection.

The registered manager discussed issues and events with staff during team meetings. Changes, updates and reminders of practice were given so that staff were aware of what was expected to of them. Had individual evacuation plans in place for in the event of an emergency. Staff had received training and taken part in fire drills. Staff were familiar with that they needed to do.

Good

Is the service effective?

Our findings

People were supported by staff who received training and regular supervision. One staff member said, "Supervisions are regular, we are asked if everything is ok, or if we want to work towards anything." Training was delivered by both eLearning and face to face learning and staff competency was checked by the provider's trainer. People who lived at the service felt staff had the appropriate skills for their role.

Staff told us that they felt that the training was relevant and they felt supported by the management team. One staff member said, "Training is good. E-learning and practical (training was provided). Every year come up moving and handling, safeguarding, first aid. We do theory and then [provider's trainer] does the practical." New staff completed an induction and the nationally recognised care certificate. This is training that prepares staff who work in a care setting.

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 that, as far as possible, 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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA were being met. The management team had identified that this was an area that they needed to develop so had been working with the local authority to train the staff. As a result, staff now had a better understanding of the assessment process and these were being reviewed and re written.

People were supported to enjoy a variety of food. One person told us, "The food is nice you get an alternative its good choice." A relative told us, "[person] is fed so well she is moaning she is eating too much but still finds space for the odd biscuit." We saw breakfast and lunchtime was relaxed and people were given choices. The food looked and smelt appetising and people told us it was nice. The tables were set nicely, condiments and drinks were available along with a picture menu. People had gravy on the table so they could serve themselves and where they were not able to staff helped them. People chatted and we saw it was a sociable experience. The kitchen staff had a list of dietary needs and preferences which helped them when they prepared the food. We noticed the trolleys were plugged in when they arrived in the units to ensure they maintained a safe temperature. However, staff must ensure that they don't leave trolleys uncovered when they are offering choices so the food doesn't drop in temperature.

Where people had been assessed as being at risk of not eating and drinking enough, or had lost weight, and in most cases the food and drink intake charts were held. We saw some people had been referred to the speech and language team. The GP had been consulted but this was not always recorded when requests

had been made for supplements and if fortified foods were given in order to increase people's calorific intake and to promote weight gain. The registered manager monitored people's weights and we noted on the day of inspection instructed a staff member to request a supplement for a person who had lost weight. We discussed the need to ensure that all actions taken should be reflected in people's individual assessments and care plans.

People had access to health and social care professionals and there was a regular GP round. Those people who needed to see the GP were discussed at the management teams daily 'Take 10' meeting. Other health professionals attended people at the service, which included nurses and mental health professionals. People also had access to a chiropodist and a hairdresser. A relative told us, "The hairdresser is also a wonderful addition to the home, she is such a lovely lady and makes my [relative] feel herself again, she even takes the time out of her busy schedule to pop in and see my [relative] when she doesn't even have an appointment, which is always appreciated."

The design of the building meant that people could walk around freely, spend time in different communal areas and the garden. Bedrooms were personalised. One relative said, "[Person] has a lovely room, which is always clean and [name] the caretaker has done their best to make it as homely as possible putting up any pictures [they] requested to make the transition from [their] flat to the home as smooth as possible. [Caretaker] is always around to assist with anything like when we wanted a fridge in [person's] room they were happy to help with this."

Good

Is the service caring?

Our findings

People told us that staff were kind and they enjoyed living at the service. One person said, "I find staff to be nice and helpful." Another person told us, "I am happy here. I feel they are good with my privacy and dignity." A relative said, "The carers do an outstanding job, I think to carry out the job they do you have to be very special, I couldn't do it and I have so much respect for them. [Staff member] is fabulous my [relative] loves them, [names of care staff] are always around and [relative] often mentions them or tells us stories about when they popped in." Another relative told us, "The staff are so friendly and helpful and I would recommend this home to anyone seeking help with a relative."

People and their relatives, as needed, were involved in planning and reviewing people's care. Where relatives were involved, there was documentation which supported their legal right to be involved. Plans included life histories, family trees, what was important to people and their preferences. People told us staff were good at asked them what they wanted. They told us they could get up or go to bed when they wanted. Staff were very knowledgeable about people`s likes, dislikes and preferences and we saw they knew people well. One person told us that they had a challenging time before moving into the service. They said, "When I moved in staff were aware (of their previous difficulties) and I found them understanding." One staff member said, "I like it because it's a good team and the residents are nice. We get to know them well." Staff told us that they would be happy for a relative of theirs to live at Wisden Court. A staff member said, "The staff are very caring."

People's privacy and dignity were respected. We noted staff knocked on doors and were discreet when supporting them. One person said, "I can lock my door and staff will always knock on the door and they respect my privacy and dignity. I lock the door because some people walk around and they try to open my door so I lock it. Staff have a key if they want to come in." People's records were stored in locked offices to promote confidentiality for people who used the service.

People had developed friendships with other people living at the service. We noted that people got together in the lounges and at the dining tables and were chatting. Relatives and friends of people who used the service were encouraged to visit at any time and felt welcome.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us that their needs were met and most were happy with the way they were supported. One person said, "I find staff knows us residents and they look after us well." A relative told us, "The whole care team are amazing, we visit the home [frequency] and observe how the care team take care of all residents and they always treat the residents with respect, care and patience." Another relative told us, "[Person] is always clean and well dressed." However, some relatives told us that needs were not always met. One relative said, "When my [family member] first arrived at Wisden Court there wasn't as much help as we'd expected. They assumed [they] could do more as their speech was good, so they didn't get the required help and ended up walking around the home naked looking for help to get washed and dressed. They also should have found out about their likes and dislikes and care requirements from relatives and other carers when they arrived." Another relative said, "I have repeatedly asked for them to use steridentthat we supplied and this is not happening. Their gums are sore, they tell us and I worry that if their teeth are not clean this could be not helping."

We noted that people's needs were met on the day of inspection and staff had a checklist that was to be completed which ensured all areas were met. This included checking if people's hair was combed, oral care had been provided, clean clothes were being worn and people were dressed appropriately for the weather. For example, socks and stockings.

However, the checklist had not been completed on the day of inspection when we reviewed it after lunch. We noted that several people did not have socks or stockings on. We discussed this with the deputy manager and care team manager. They told us this was the people's choice. However, this was not reflected in people's notes or care plans and we could not be sure that people, in particular those living with dementia, were able to verbalise or given this choice during personal care. The care team manager [CTM] told us that they had asked one person, whose plan said they liked to wear stockings, but they said they didn't want them on. However, when the staff member checked this persons room they found there were none available so would unable to wear stockings if they had chosen to wear them. The staff member said they would ask the family to provide some. We discussed with the registered manager whether or not this would have been picked up if we hadn't raised it. We also noted that some men had not received a shave. Ensuring people consistently received person centred care was an area that required improvement.

People's care plans had been developed following the last inspection. The plans were now much more person centred and guided staff on how the person needed to be supported and also their preferences. The plans included preferred times of getting up, the toiletries they liked to use and ways to communicate with people. However, we also noted that one person, who was living dementia, had it stated in their plan that they liked a pale colour nail varnish and a cardigan over their jumper as they didn't like to feel cold. We found that they had bright nail varnish on and no additional cardigan. They were unable to verbalise to us if this was their choice. We raised this with the management team and explained that fluctuating choices need to be reflected in plans so if care is delivered in a different way, they can be sure it is the person's wishes rather than staff not being aware of the person's preferences.

Some further improvements were still ongoing and one person, who had moved in permanently almost two weeks prior to the inspection did not have a completed plan. The blank care plan was on a desk in an office awaiting completion. The plan in use during their respite stay could not be located until after the inspection. The registered manager later confirmed by e-mail that this person's care plan had now been completed. However, this meant that staff during the first two weeks of this person stay at the home staff had no access to information about this person's needs and this had not been identified as a concern. Although this issue had been addressed at the time of writing this report, a more structured system should be in place to ensure that information about people's needs is always available should it be needed to be referred to. Care plans were an area that required improvement.

People were supported at the end of their lives at Wisden Court. There were plans in place so that staff could support them in a way they liked and enabled them to die with dignity and pain free. Plans detailed if people wanted to stay in the home or go into hospital. The plans also had contact details of funeral directors and what songs to be played at their funerals. However, we discussed with staff the importance of involving a GP at regular intervals to possibly avoid the need for coroner intervention which can cause a delay and more disruption for families.

Complaints and concerns raised had been investigated. Letters were sent to the complainants and the management team acknowledged if they had failed in an area, they included an apology. However, the tone of some of these responses could come across as quite harsh and the content would benefit from being softened so people can feel confident with raising concerns. Complaints were shared with the staff team to help ensure these did not reoccur. People and their relatives told us that they knew how to raise concerns. One relative said, "If I have any concerns I know I can ask anyone and they are all willing to help." However, another relative told us, "There does also seem to be a reluctance to work together with relatives to resolve issues. Often we feel that when concerns are raised then senior staff can be a little heavy handed in their responses and try to turn the concerns round on the relatives to suggest that it is something we have done wrong rather than working in a collaborative way with us to find a solution." This was an area that required improvement.

People and their relatives were asked for their views through satisfaction surveys. The recent survey had just been issued. Results from a previous survey were mainly positive. We saw where suggestions had been made for changes to the menu, these had been included on the menu.

Activities were an area that needed improvement at our last inspection. At this inspection we found that these now included more people, were more regular and were activities that people enjoyed. People told us there were activities provided during the morning as well as in the afternoon. They were happy with the choice of activities. People had been asked what they enjoyed and these had been added to the schedule. A relative told us, "[Name] the lady who hosts all of the activities is fabulous, my [relative] doesn't tend to socialise, but this isn't down to [staff member] not trying, she still pops in to check on [relative] which is so kind." Another relative told us, "[Person] seems to always be busy when we go to visit, today they were making gingerbread."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found that care plans, activities and the way some care was delivered needed to be improved. In response to this, care plans had been re written which made them more person centred, activities had been further developed and people had been asked what activities they wanted and a monitoring tool was implemented which was to help care was given in a way they expected. We found that there had been improvement in relation to activities. Staff were informed of the issues and reminded what was expected. However, we did find that staff did not always follow these instructions. For example, with daily counts of medicines and checks around the home.

There were a range of audits and checks completed to assess the quality of the service, identify any issues and prompt staff to ensure they had completed tasks to the appropriate standards. Where shortfalls had been found, action plans were put into place to address these. There were plans to transfer records to electronic format and care plans to be managed from devices in the future which they hoped would eliminate some issues found on inspection. However, although there was a clear management structure in place and there were tools available for monitoring, these were not effectively used. This resulted in care not always being delivered in a person-centred way. Medicines were not being consistently managed safely and some records, mainly care plans, were not being maintained. We also found that concerns in regards to staffing deployment had not been identified through quality systems and the association between this and times of frequent falls had not been made. This was an area that required improvement.

People and their relatives were mostly positive about the registered manager and how the service was run. A relative told us, "The home manager [name] is fabulous, they are always available to speak to, nothing is ever a problem, they have a lovely caring manner and you can tell that residents are important to them, [registered manager] is assisted by [deputy manager] who again is lovely, always happy to help and keep us updated." We noted that people and their relatives were confident to pop into the office to see the registered manager.

The registered manager was supported by a deputy manager and care team managers on each shift. A relative said, "All we can say is this is our first experience of a home situation and we were very nervous and apprehensive as you hear so many horror stories through the press. We cannot express how happy we are with Wisden Court and all the staff from the Management, Carers, Kitchen staff, cleaners everybody deserves a huge pat on the back from us as the whole process has been made easier for us as a family thanks to [registered manager] and ALL their staff." Another relative said, "My praise for this home and the work they do so very well, without Wisden Court our lives would be so different and so stressful. This is only our view but Wisden Court is wonderful."

The provider worked with the local authority who commissioned beds for people. The had a recent visit and were working through an action plan developed in response to the visit. We also noted that they made regular contact with us to keep us informed of events in the home.

Staff had regular meetings and were asked for their views through a survey. A recent survey had been

completed but an action plan had not yet been developed. The outcome was mainly positive with just a few areas that the registered manage wanted to explore. Staff felt that the registered manager listened to them but understood that the control on number of staff working was out of their remit. Staff told us they liked to work in the home and it was a good team. Staff we spoke with worked there for a number of years and were clear of their job roles and responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that peoples' safety was consistently promoted.