Runwood Homes Limited

Plantation View

Inspection report

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Date of inspection visit:
16 May 2018

Date of publication:
14 June 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 16 May 2018 and was unannounced. This means prior to the inspection people were not aware we were inspecting the service on that day.

Plantation View is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Plantation View is a purpose built care home situated in the Cantley area of Doncaster. The home accommodates up to 27 older people that require assistance with their personal care needs. On the day of our inspection there were 26 people living in the home.

There was a registered manager in place for the service. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last carried out an unannounced comprehensive inspection of this service on 4 April 2016. At that inspection the home was rated as Good. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Plantation View on our website at www.cqc.org.uk.

At this inspection we found the service remained Good. However we have rated the 'Safe' domain as 'Requires Improvement'. This was because we found staffing levels were not always sufficient to ensure people were supervised, had their privacy and dignity maintained and were provided with a programme of social activity. We found people's care needs were met in a timely way, but this meant staff were very busy carrying out care tasks so they had very little time to socialise and spend quality time with individual people.

Risks to people were routinely assessed with clear plans to keep people safe. Where incidents had occurred, staff responded appropriately and the registered provider analysed incidents so that further occurrences could be prevented. Staff understood their roles in safeguarding people from abuse.

People's medicines were managed and administered safely. The registered provider had carried out appropriate checks on staff to ensure that they were suitable for their roles.

People were supported to access the healthcare they needed and staff worked alongside relevant agencies to meet people's health needs. People received a thorough assessment before going to live at the home and individual needs and choices were documented and met.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

People told us they enjoyed the food and it met their dietary needs. People were supported by staff that had received appropriate training to carry out their roles with confidence. People were supported by kind and caring staff that they got on well with.

There was no activity worker which meant people only had access to a very limited range of social activities. People's wishes regarding end of life care were documented.

People were informed about how to raise a complaint and the registered provider regularly asked people for feedback. Regular audits were undertaken to measure the quality of the care that people received. There was clear leadership at the home and staff told us they felt supported by the management team.

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 has deteriorated to Requires Improvement	**Requires Improvement**
Is the service effective? The service has improved to Good	**Good**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service remains Good	**Good**

Plantation View

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.

We undertook an unannounced comprehensive inspection of Plantation View on 16 May 2018. This inspection was unannounced which meant no one at the service knew we were coming.

The inspection was undertaken by one adult social care inspector and an expert by experience, with expertise in the care of older people. An expert by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection visit we gathered information from a number of sources. We looked at the information received about the service from notifications sent to the Care Quality Commission by the registered provider. We also spoke with the local authority commissioners, contracts and safeguarding officers and Healthwatch (Doncaster). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used information the registered provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

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

Throughout the inspection we also spent time in the communal areas of the home observing how staff interacted with people and supported them.

We spoke with nine people who used the service, three of their relatives, the registered manager and staff members including care team managers, care workers and ancillary staff. We also spoke with two visiting

healthcare professionals.

We looked at four care plans, medicine records for three people, staff duty rosters and records associated with the monitoring of the service, including audits.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living in Plantation View. Their comments included, "My sons chose it so they must have thought it was safe, or they wouldn't have put me here," "I'm fine and safe," "I'm lucky to be in here, yes I'm safe" and "Yes I feel safe and my room is lovely."

The registered manager used a 'staffing tool' to assess the number of staff required in order to meet the needs of the people living in the home. This showed staffing was maintained above the minimum required; however feedback from people, relatives and staff was that more staff were needed during busy times. The staffing dependency tool did not take into consideration the layout of the home, which was spread over a large area, making it difficult for staff to observe people.

During the inspection we observed a number of times when staff were not available in the communal areas of the home which could pose a risk to peoples' wellbeing. Enough staff were provided to meet the needs of people, however staff did not have much additional time to spend with people socialising and enhancing their wellbeing. The registered manager told us all people who used the service had a diagnosis of dementia. We saw the majority of people were independently mobile and moving freely around the home. This was important for people but did mean it was more difficult for staff to supervise people closely. This also added to the risk of altercations and confrontations between people who used the service.

Staff were knowledgeable about safeguarding and whistleblowing procedures. They were able to clearly explain how they would report any concerns they had and who they would report them to. A safeguarding and whistleblowing policy was available to guide staff in their practice and contact details for local safeguarding teams were available. This meant people were protected from harm and staff were familiar with the necessary reporting procedures.

We saw risk assessments contained information for staff to follow in order to keep people safe. For example, a mobility risk assessment for one person who had recently suffered a number of falls had been updated. The necessary referrals had been made to the falls prevention team, there was regular correspondence with the GP, half hourly observations were being conducted and a sensor mat had been provided to mitigate risk. This meant people's health and wellbeing was being monitored, assessed and information being recorded was up to date and relevant.

Staff responded appropriately to accidents or incidents and the records supported this. For example, four people had recently sustained minor injuries. In response to each incident staff provided first aid, took the person to hospital if necessary and reviewed each person's care plan. The registered manager held records which analysed and reviewed incidents which meant they could respond to any trends they identified.

Each person had their medicines safely stored in their room, from which they were administered by senior staff. All staff who were administering medication had received the necessary training and had their competency assessed in this area.

We reviewed medicine administration records (MARs) and found prescribed medicines were being administered at the required time. There was a system in place to manage and monitor MARs on a daily basis so that any errors could be rectified promptly.

We reviewed how medicines that were prescribed 'as and when' needed, also known as 'PRN', were managed. PRN protocols were in place to inform staff when to administer these medicines. For example, one protocol stated the medicine could be administered to the person when they were feeling pain. The protocol detailed when the medicine should be administered and the non-verbal clues the person could display which would indicate they needed the medicine.

There was a medicine policy available which included information on how medicines were ordered, stored, administered and disposed of. Medicines were stored securely and the temperature of medicine areas were monitored and recorded. If medicines are not stored at the right temperature, it can affect how they work.

Safe recruitment procedures had been followed and appropriate employment checks were being completed. All staff files we reviewed contained two references, photographic identification, detailed employment history and evidence of Disclosure and Barring Service (DBS) checks. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults.

Health and safety processes and systems were reviewed to ensure the home remained safe. Repairs and maintenance were carried out in a timely way, and there were regular checks on equipment such as the lifts, portable appliance testing (PAT), electric and gas. Fire procedures were in place and Personal Emergency Evacuation Plans (PEEPs) were in place for each person who lived at the home. These are personalised plans which staff need to consult in the event of an emergency situation. PEEPS contained the relevant and most up to date information about each person's level of mobility support needs.

The home was clean and free from odours. Personal protective equipment (PPE) was available for all staff, such as gloves and aprons.

Good

Is the service effective?

Our findings

People told us they liked the food. Their comments included, "I don't like meat so I have something else like fish," "Foods good here I'm happy with it and we get plenty of tea, coffee and juice," "I like all my food I get plenty. This piece of cake is lovely," "I'm well fed, the food is always nice and hot" and "I don't like porridge so they get me something else."

During the inspection we observed the quality and standard of food people received. We observed well-presented and appetising meals being offered and people had a choice of what food they wished to eat. People were shown a plated sample of the options available at lunchtime. We saw people responded well to this and were easily able to decide upon their preference.

People's nutritional support needs had been assessed and were routinely monitored. The necessary referrals to the dietician or speech and language therapist were taking place when required. Advice from these professionals had been included within care plans to ensure staff were aware of any further support which was required. Weekly and monthly weight charts were in place and completed accordingly, as well as food and fluid intake charts. These are completed when there is a concern regarding people's intake, the charts monitored how much people were eating and drinking.

People were supported by staff and external healthcare professionals in order to maintain their health and wellbeing. Care files showed advice was sought from professionals such as the district nurses, GP, dietician, speech and language therapist, and opticians. Advice and guidance provided from these professionals was incorporated within the care plans and staff were familiar with guidance which had been provided. One healthcare professional told us, "I have no concerns at all with this home they are one of my most organised I know. I have no problems at all. Staff are especially brilliant and always inform me of any changes to the health of people."

People's needs and choices were assessed before they came to the home with regards to their personal care and preferences. Admission assessments also detailed people's medical conditions and any needs associated with these. This gave staff the guidance they needed to support people to experience good outcomes in relation to their healthcare needs.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed the relevant DoLS applications had been submitted to the local authority. Information regarding DoLS was also clearly recorded within the necessary care plans. People told us staff always asked them for their consent before providing support and we observed this during the inspection. Care files contained records of people's consent in relation to photographs, care and treatment and when people were unable to provide consent, decisions were made in people's best interest in line with the principles of the MCA.

During this inspection we found staff were being provided with training, learning and development opportunities as well as receiving the necessary supervision and appraisals. On-line and classroom training was available and all staff were encouraged to complete a mixture of both mandatory and non-mandatory training. The registered manager had oversight of what training had been completed and where training improvements where needed. Training which had been completed included health and safety, food hygiene, infection control, safeguarding, fire safety and dementia awareness.

New staff were expected to complete on-line modules which were in line with 'The Care Certificate'. The Care Certificate is a new set of minimum standards that should be covered as part of induction training of new care workers. Staff told us, "The training is good and we get put on it when we're due" and "There's been lots of training, I've really enjoyed it."

Good

Is the service caring?

Our findings

People told us they were well cared for and that the staff were kind. Their comments included, "I didn't feel well today so the staff let me stay in bed," "The staff are very kind. I'm spoilt here," "Everything is nice in here there is nothing I would change" and "They are nice and look after me well."

Relatives told us, "This place is brilliant, always clean and tidy," "Dad needs his ears syringing but he won't let them. They are very patient with him" and "[Name] is very comfortable here. They are very good with her and she can be very nasty."

The interactions we observed between people and staff demonstrated kindness and compassion. In the morning we observed care taking place as people got out of bed and prepared for the day. We saw and heard people laughing and chatting with staff in their rooms whilst being supported and cared for.

During the inspection we observed interactions between staff and people who were living at Plantation View. Interactions between staff and people were warm and friendly. Wherever possible staff tried to spend time with individuals but were seen to move from one task to another as quickly as possible. During busy times staff were seen walking quickly around the home without acknowledging and responding to people's requests. For example, when one person asked if staff could get their handbag they were told they would have to wait until staff had time. Although this was not said in an unpleasant way the person was clearly unhappy that they were being told to wait and said, "Not again. I always have to wait." The person was given their handbag soon afterwards.

It was clear staff knew the people they were caring for well. Staff could explain and describe people's needs as well as their likes, dislikes and preferences. Care plans we reviewed also reflected people's preferences with regards to food, hobbies and times they liked to get up or go to bed. This enabled people to be supported by staff that knew them well and provide care based on their individual needs and preferences.

Care files showed people were encouraged to remain as independent as possible, whilst remaining safe. For example, one person's mobility care plan showed that a sensor mat was being used to alert staff when they mobilised during the night, as they were at high risk of falling. This enabled the person to continue mobilising when they wanted to, but for staff to support them to remain safe.

We reviewed the 'Service User Guide' which was provided to people and relatives from the outset. This contained important information about Plantation View such as the management team, staffing structure, accommodation and facilities and what could be expected when a person moved in. The 'Service User Guide' was dated March 2015 and we found some information required updating. The registered manager said they would update this immediately.

For people who did not have any friends or family to represent them, details of local advocacy services were made available. Advocates represent people when specific choices and decisions need to be made in relation to their health and support needs. On the day of the inspection we saw one person go out on a

home visit with their social worker and advocate.

Good

Is the service responsive?

Our findings

Care plans we looked at were detailed, reflected people's individual needs and preferences and were regularly reviewed. This meant staff could familiarise themselves with the most relevant and up to date information.

Care plans were tailored to each individual and reflected each person's needs and preferences. We saw a 'one page profile' called 'My day' was in each care plan. This included personalised information about the person's life, education and employment, family members, place of birth and other significant details to enable staff to get to know people as individuals. One healthcare professional told us, "The care plan information is 100% improved and communication between us and the service is extremely good. The service is getting better and better."

People received appropriate and sensitive end of life care. Care plans were in place that recorded people's wishes and preferences at this stage of their lives. Important information, such as people's religious needs or whether people wished to go into hospital or remain at the home were clearly documented. One relative told us, "They know to contact me either day or night if there is any change in my [family members] health."

People were able to raise a complaint if they wished. Their comments included, "I could happily go to anyone and tell them if I wasn't happy with something," "If I had a problem I'd talk to the staff or manager" and "The staff will always try to sort things out if we complain about something."

There was a clear complaints policy displayed in reception area at the home and also in the 'Service User Guide' given to people when they were admitted to the home. We looked at the complaints file and saw complaints received were being recorded and responded to appropriately. The service had received two complaints in the last 12 months and these had been investigated and resolved.

There was no activities co-ordinator in post at the time of the inspection which meant care workers had the responsibility for providing social activities. The general consensus from people who used the service and their relatives was that there was not enough social activities available. Their comments included, "We don't do much or go out and I have no one to take me," "I'm very lonely, it's a lonely life in here with nothing to do," and "I don't do anything just sleep. I like football and watch that on TV sometimes."

Information displayed around the home showed such things as outings, crafts, activities, exercise and sing a longs had taken place or were due to take place over the coming months. The registered manager told us the registered provider had said when occupancy increased at the home they would be providing a dedicated activities worker. The registered manager said as occupancy had increased this was something she was implementing and dealing with as a matter of urgency with the registered provider.

The registered provider had employed a 'Dementia Services Manager.' They had carried out one introductory visit to the home and informed the registered manager they would be making regular visits to support the staff due to the number of people living at the home with complex needs and the lack of an

activity coordinator.

Good

Is the service well-led?

Our findings

During the inspection we found the service was well-led. The quality and standard of care being provided and the governance of the service was being continually assessed so that people were provided with good care. Local audit systems were effective in identifying areas of the service which needed to be improved and were being used as a measure of improving quality and standards.

At the time of the inspection there was a registered manager in post. They had been registered with CQC since September 2017. The registered manager was aware of their responsibilities and it was evident she was well liked and respected by people involved with the service. Their comments included, "The manager is good and always there if we need her" and "We have a good management team who are approachable and accessible."

The registered provider had recently appointed the support of an external consultant to help assess and improve the standard and quality of care which was being provided. The registered manager told us they had received their initial findings but were waiting for the full report so that an action plan could be formulated. The initial findings had highlighted concerns around the observation of people who used the service due to the staffing numbers and layout of the service and also the provision of suitable activities and stimulation for people.

We saw evidence of staff meetings, resident/relative meetings and management meetings. There was a range of different topics being discussed such as accidents/incidents, medication, staff training, governance, menus, communication and recruitment. This meant people, staff and relatives were all involved and encouraged to share their thoughts and opinions about the provision of care people were receiving.

Communication books and daily contact notes were regularly updated. There was a staff handover at the beginning of each shift when staff were requested to attend to discuss any significant events, concerns and daily activities which were taking place. Staff spoken with said the level of communication had significantly improved and they felt involved in the decisions made about the care being provided to people.

A range of different policies were reviewed during the inspection which included administration of medication, whistleblowing and safeguarding. We saw policies were up to date, had been reviewed and contained reference to current legal or policy requirements.

The registered manager had notified the Care Quality Commission (CQC) of all events and incidents that occurred in the home in accordance with our statutory requirements. This meant that CQC were able to accurately monitor information and risks regarding Plantation View.

Ratings from the last inspection were displayed throughout the home as well as being available on the registered provider's website as required. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the

public whether a service is outstanding, good, requires improvement or inadequate.