The Shaw Foundation Limited

Woodview House Nursing Home

Inspection report

Waugh Drive
Hagley Road, Hayley Green
Halesowen
West Midlands
B63 1EN

Tel: 01215856440
Website: www.shaw.co.uk

Date of inspection visit:
03 February 2016
04 February 2016

Date of publication:
01 April 2016

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**

Summary of findings

Overall summary

Woodview House Nursing Home is registered to provide accommodation and personal care for a maximum of 24 older people with a diagnosis of Dementia or mental health needs. At the time of our inspection, there were 23 people living at the home.

Our inspection took place on 3 and 4 February 2016 and was unannounced. Our last inspection took place in April 2014 and the provider was compliant in all areas inspected.

There was no registered manager in place at the time of our inspection. However, there was a manager registered for the service. As part of the conditions of their registration, the provider is required to have a registered manager in post. 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. We saw that recruitment was on-going to find a new registered manager.

The provider has a legal responsibility to notify us when someone is being deprived of their liberty but had not notified us of a number of Deprivation of Liberty authorisations. This meant that the provider was not meeting the legal requirements of their registration. You can see what action we told the provider to take at the back of the full version of the report.

People were not always supported in a safe way as information about the risks posed to people were not always communicated to staff effectively.

We saw that staff were able to identify types of abuse and knew the actions to take if they suspected someone was at risk of harm.

There were errors in the recording of what medication had been given to people which meant the provider was unable to evidence that medication had been given as prescribed.

Staff were not always aware that people had Deprivation of Liberty Safeguards in place and so were not able to demonstrate how they support people in line with their DoLS authorisations.

People were not always given choice at mealtimes. Details of the meals people could choose from were not displayed in a way that would support people to understand their choices.

Staff were not always caring in their interactions with people. We saw that that there were long periods of time where staff could have been interacting with people but did not.

We saw that there were a lack of activities available for people. Staff told us that the activities that were

available were not appropriate for the abilities of the people living at the home. We saw that staff responsible for doing activities were often completing other tasks.

Quality assurance audits completed by the manager did not always identify areas for improvement and where issues had been identified; action had not been taken to reduce the risk.

We saw that there were sufficient amounts of staff available to meet people's needs. Where staff shortages were identified, there were systems in place to ensure temporary staff were used.

Staff were supported in their role as they received an induction and training to give them the knowledge required to support people. However, the training was not implemented effectively to ensure staff had the skills needed to support people in a way that kept them safe.

People were supported to maintain their health and well-being by having access to healthcare professionals when required.

People were encouraged to make decisions about their care. If they were unable to their relatives were involved in how their care was planned and delivered.

People knew how to make complaints. Where a complaint had been made, this was investigated and resolved by the manager.

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.

Medication records had not been accurately kept which meant the provider was unable to ensure that medication had been given as required.

Risks to people were not always communicated which meant staff did not always have the information required to support people safely.

Staff knew the actions they should take if they suspected someone was at risk of harm.

There were sufficient amounts of staff on duty to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not have knowledge of who had a Deprivation of Liberty Safeguard in place and how they should support people in line with this.

People were not supported to make choices about meals. Information about the meals available was not displayed in an accessible way.

Staff received training to support them in their role.

People were supported to maintain their health and wellbeing by having access to healthcare professional support where required.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always respond to people in a caring way when people were distressed.

People and their relatives were supported to express their views about their care.

Staff could explain how they treat people with dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were a lack of meaningful activities available for people. Activities made available were not always suitable for people's level of ability.

People were not always involved in the planning and review of their care. Relatives were involved in this on people's behalf.

Complaints procedures were in place for people and relatives to voice their concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

Deprivation of Liberty Safeguards (DoLS) approvals had been made but the provider had not notified us of these as is required by law. This meant that the provider was not meeting legal requirements.

Quality assurance audits had not identified where improvement was required. Where the management had identified issues, these were not acted upon to reduce the risk of the issue reoccurring.

Staff felt supported by the manager and were confident that any issues raised, would be dealt with appropriately.

Woodview House 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 on 3 and 4 February 2016 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of caring for a person with dementia.

We reviewed the information we held about the home including notifications sent to us by the provider. Notifications are reports that the provider is required to send to us to inform us of incidents that occur at the home. We also spoke with the local Healthwatch team about the information they had received about the care provided.

We spoke with eight people living at the home. However, these people were unable to verbally tell us their views of the service and so we used a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand people's experience of the service. We spoke with four relatives, four members of care staff, one member of staff from the activity team, one member of the kitchen staff and the acting manager. We also spoke with a health professional who was visiting the home.

We looked at the care records for two people, two staff recruitment files and eight medication records. We also looked at records kept of accidents and incidents, complaints, staff training and quality assurance audits completed by the manager.

Requires Improvement

Is the service safe?

Our findings

Relatives we spoke with told us they were happy with how their family member's medication was managed. One relative said, "[Relative] always gets their medication on time". We observed a medication round and saw that people were given their medication by staff who explained what they were doing and were patient so that people could take their medication in their own time. We looked at where medications were stored and saw that these were stored safely. We saw that daily temperature checks took place and monthly check of medical equipment was carried out.

We saw that for three medication records, the amount of medication available did not match what the records stated should be available. We saw that the provider used an electronic system to record what medication had been given. For one medication, we saw that the system had failed to save an entry made by a member of staff that morning. For a second medication, the staff member responsible had not recorded that a certain medication had been given. This meant that the provider could not evidence that medication had been given as prescribed.

We spoke with staff responsible for handling medication who informed us that the electronic system had been difficult to use and so in some instances, handwritten Medication Administration Records (MAR) were used instead. The paper records we saw did not always match the records held on the electronic system. As this information was recorded in different places, there was no accurate record detailing what medications had been received into the home and how many were remaining. This meant that there was no accurate record available of what medication people had been given.

We saw that there were protocols in place informing staff of when 'as and when required' medications should be given. However, these protocols were kept with paper MAR charts used in the previous system and not within the electronic system the staff currently used for medication. This meant the information about when to give these medications were not readily available for staff. We asked a member of staff if they knew when 'as and when required' medications should be given. The staff member told us that they use their discretion and knowledge of the person to identify when the medication is needed. This meant that people were at risk of not receiving their 'as and when required' medication in a consistent manner.

Staff we spoke with could provide examples of how to manage risks and keep people safe. This included ensuring equipment is in working order and checking for wear and tears. Staff told us they were kept up to date with any changes in risks posed to people in the communication book. One member of staff said, "If the care has been updated, it gets put in there [the communication book], we have to read it before each shift". However, we saw an incident where a person living at the home needed support to get from chair to chair. We saw two staff members attempt to support the person to stand in a way that put the person at risk. Staff later recognised that they were not aware that the person's care needs had changed and they could no longer be supported in this way. This change in needs had not been recorded in the person's records. We spoke with a number of staff about this person and not all knew that this person's needs had changed and that they now required the use of a hoist. This meant that risks to people were not communicated effectively to ensure people were supported in a safe way. We spoke with the registered manager about this, who

informed us they would address this person's new care needs with the staff team.

We saw that people felt safe. Where people were anxious or distressed, we saw that staff responded to this and people visibly relaxed once around staff. We saw that one person was being supported to move from one chair to another with the support of a hoist. To ensure the person felt safe, staff held the person's hand and talked them through what was happening. Relatives we spoke with also felt their relative was safe at the home. One relative said, "Yes, [relative] is safe". Another relative told us, "The home feels safe".

Staff we spoke with could identify the different forms of abuse and knew the actions they should take if they suspected someone was at risk. One staff member told us, "I would go to the person in charge. If I couldn't I would go to Care Quality Commission". Staff told us and records confirmed that staff had received training on how to safeguard people from abuse. We saw that the manager had reported safeguarding incidents appropriately.

We saw that accidents and incidents were analysed to identify trends and reduce the risk of accidents re-occurring. We saw that a report was completed monthly and where a person had two or more accidents within that month, their care is reviewed and the manager would record actions to minimise the risk in future. We saw that actions taken had included medication reviews following people having falls, and psychiatric referrals and trials of de-escalation techniques for people who had displayed behaviours that challenged . These techniques are ways of supporting a person to relax before any potential behaviour can escalate.

There were effective recruitment systems in place. Staff we spoke with told us that before starting work, they were required to provide two references and complete a check with the Disclosure and Barring Service (DBS). The DBS check would show if the prospective employee had a criminal record or had been barred from working with adults. Records we saw confirmed these checks had been made.

Relatives we spoke with felt that there were enough staff on duty to meet people's needs. One relative said, "There is a lot of staff, there is always someone with [relative]". Staff we spoke with felt there was not always enough staff. One staff member said, "Occasionally there are enough staff but more often than not, no". Another member of staff told us "Most shifts there are enough staff, sometimes we could do with more". Staff we spoke with felt the staffing issues were due to people's care needs increasing and the high number of agency staff being used. Staff we spoke with told us, and records confirmed that there had been occasions where there were more agency staff on duty than permanent staff. We saw that there were sufficient amounts of staff on duty to meet people's needs. This included support from staff who were employed to support people with activities. We saw that there were always staff available in the communal area and that where emergency call bells were pressed; these were responded to in a timely manner. The manager informed us that due to an increase of the care needs of people living at the home, they were in the process of recruiting more staff to meet people's needs. We saw that recruitment was on-going and that the manager had systems in place to ensure agency staff were available to cover vacancies. We saw that where agency staff were used, they were given an induction into the home before being allowed to start work. We saw that the same agency staff had been requested for cover to ensure people had chance to become familiar with the staff providing their care.

Requires Improvement

Is the service effective?

Our findings

We observed that people were not given a choice of meals. One relative who often supported their family member to eat their meals confirmed this. The relative told us, "I give [my relative] what they give me unless it's something they won't like". We saw one person being given their breakfast without being asked what they would like to eat so we spoke with kitchen staff about how this person had chosen their food. The member of staff told us, "This is what [person] always has". This person was not able to verbally inform staff of his choice and we observed that he wasn't supported to choose a meal by alternative methods of communication. We saw that the details of the meals that were available were not provided in a way that would be accessible to people to aid them in choosing their own meal.

We observed that lunchtime was a busy experience for people. We saw that tables were not set with cutlery or any other indicators for people to show that it was lunchtime. The dining area was crowded with staff waiting for meals to be served from the kitchen.

We spoke with kitchen staff who knew people's dietary requirements and ensured the meals they were provided with met this. However their knowledge of people's likes and dislikes with food were limited and we saw that people were not given choice that reflected their preferences. We saw that people's dietary requirements were recorded in the kitchen. A member of kitchen staff told us that people would be offered a sandwich if they did not want the meal that was provided to them. We did not see any alternative meals being offered to people or that choices other than sandwiches had been offered.

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 when this is in their best interests and legally authorised under the MCA. The application 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. Staff we spoke with told us they gained consent from people before supporting them. One staff member said, "I ask people rather than tell them and I allow them time to answer". For people who were unable to verbally give consent the staff member told us, "For those who can't talk, I know their nonverbal signs; for example one [person] will reach their hand out". We saw that staff sought people's permission before providing them with support. We saw that where people lacked capacity, assessments had been carried out and best interests meetings held. The manager told us that DoLS authorisations had been granted for six people and applications had been made for a further seven. These applications had been made appropriately. However, staff we spoke with did not have an awareness of who required a DoLS and the reasons for these. Without this knowledge, staff would not have an understanding of how people with a DoLS in place need supporting and how to ensure they are not unlawfully restricting people.

Relatives we spoke with told us they felt staff had the knowledge to support their family member. One relative told us, "The staff are skilled, staff know [person] well and what they are trying to say, [person] has confidence in them".

Staff we spoke with told us that prior to starting work, they were given an induction to the home. This ensured that the staff had the knowledge required before supporting people. One member of staff told us, "I just observed for the first week, I couldn't do things until I had the training". Another member of staff told us, "Induction was four days of training and then two weeks of shadowing". Staff told us and records confirmed that staff received training to support them in their role. Newly recruited staff told us they were completing the Care Certificate. The Care Certificate is a set of standards designed to equip staff with the knowledge they need to provide people's care. The manager told us they supported people to identify further training needs by filling out a self-assessment form about their work. This then supported staff to identify where extra training may be required. The manager also told us that staff could request extra training in supervisions. All staff spoke with confirmed they received regular supervision with their manager. One staff member told us, "Supervisions are helpful as we can raise any concerns".

Relatives we spoke with told us that their family members were supported to access healthcare services to maintain their health. Staff knew the actions to take if they felt a person was becoming unwell. One member of staff told us, "I would check if it had been reported, if not I would tell the team leader who would call the GP". We spoke with a health professional who was visiting the home. The health professional told us that staff call them promptly if they have a concern and acted on any instructions given to them to improve people's health. The professional told us, "We write down what we want [the staff] to do and they always follow it". Records we looked at confirmed that people had access to visits from dentists, opticians and podiatrists where required.

Requires Improvement

Is the service caring?

Our findings

We saw that staff did not always treat people in a caring or respectful way. We saw one staff member sat next to a person for a long period of time, and another staff member support a person to drink. The staff member's involved in these tasks did not communicate with the people they were supporting in a meaningful way, and only spoke briefly to ask the person a question. We saw a person express that they would like to wear some lipstick. The person told two staff members that this is what they would like but neither staff responded or supported the person to do this. This meant that staff had failed to treat people with dignity and promote their sense of worth.

We saw one person become distressed and attempt to grab a member of staff. This staff member did not respond in a caring way and moved away from the person without attempting to reassure them. This led to the person's distress escalating. We saw that other members of staff responded and attempted to reassure and calm the person but the first staff member's failure to act promptly in a reassuring way had led to increased distress for the person. We spoke to the manager about this who told us they would speak to the staff team and ensure they are confident in how they support people who displayed cbehaviour that could hallenge others.

Staff we spoke with were able to explain how to treat people with dignity and respect. One member of staff told us, "I make sure I close the curtains [when helping with personal care], I ask if it is ok before doing anything, knock doors before entering and cover people up during personal care". We saw some evidence of this practice. We saw staff cover a person while being hoisted to ensure they were not exposed and that where people had requested privacy, they were supported to stay in their own rooms. We saw that information was displayed about Dignity in Care day. Dignity in Care day is an initiative aimed at highlighting the importance of treating people as individuals and asking health and social care workers to promote dignity at their workplace. We saw that staff had responded to the display by posting notes around the poster explaining what this meant to them. Comments made by staff included; giving everyone chance to make their own choices and finding time to learn about each person as an individual. However, we did not always see these examples applied to staff practice. We saw that one member of staff stand up while supporting a person to eat their meal. We also saw that people had little interaction for long periods of time despite staff being available.

Relatives told us that they felt staff were kind and caring. One relative told us, "[The staff] are very kind, I can't fault them". Another relative said, "I can ask staff anything, they have been very supportive".

Relatives we spoke with told us they were involved in making decisions about their family member's care. One relative told us, "If [relative] has a fall or something, they always call and tell me". Another relative said, "Staff will contact me if there are any visits or appointments". Relatives confirmed they were supported to express their views in relatives meetings with the manager. One relative told us, "Meetings go on and anything we have to say we put to [the manager] and she always acknowledges it". We saw records that confirmed relatives were supported to be involved in meetings. We spoke with staff about how they support people living at the home to be involved in their care. One member of staff said, "We ask how people want to

be cared for by asking questions like 'would you like to get up' and 'what would you like to do', we give choice". We asked how they support people who cannot verbally communicate to express their views. One staff member told us, "You can tell by their body language and facial expressions". We saw that where people had expressed wishes about where they would like to be supported, this was respected by staff who acted on this in a timely way.

We spoke with the manager about how people are supported to access advocacy services. The manager informed us that at present no one living at the home required an advocate but could evidence where this service had been accessed by people in the past. We could not see any information displayed informing people of how they could request this support.

Requires Improvement

Is the service responsive?

Our findings

We saw that there were a lack of activities available for people. We saw people spend long periods of time asleep and where people were awake; there was little interaction between them and the staff. A staff member told us and we saw that, staff who had been employed to support with activities were often taken away from this role to help other staff deliver care to people. This meant they were unable to support people with activities. Activity records we looked at confirmed that activity staff had been supporting with care rather than undertaking activities with people.

We asked staff about the activities that were available for people. One staff member told us that there were a lack of resources available in order to provide any meaningful activities. The staff member told us they had requested a meeting with management to discuss purchasing activities for people but that this had not happened yet. We saw that there was a creative board displayed with information on the activities planned. A staff member told us, "We don't follow the board as [the activities] are not appropriate for the people here". This meant that the activities available were not suitable for people's varying levels of ability

We spoke with the manager about how they involve people living in the home in the review of their care. The manager told us that as many of the people did not have capacity or the ability to express their views, they were not involved in this process and so relatives input was sought. The manager said, "People are not involved to be honest". Records we looked at showed that people were not involved in their care planning and review. This meant that the manager had not taken the appropriate steps to ensure that people had been supported to be involved in their care by alternative methods.

Relatives we spoke with told us they were involved in the assessment, planning and reviews of their family member's care. One relative told us, "They talked to me about [the care plan], They asked all about his likes and dislikes". Another relative said, "We get invited to reviews, we had one last year". The manager told us that care plan reviews were held monthly and a formal review of people's care was held every six months. Records confirmed that the six monthly reviews took place with relative's present.

Relatives told us they felt staff knew their relative well. One relative told us, "They [the staff] know him well as we put it all to them when he first moved in". Staff we spoke with were knowledgeable about people's preferences and had a good understanding of people's life history. When asked to tell us about a person living at the home, staff were able to tell us the person's health needs, care needs and their family life. Records we looked at did not include this personalised information about people and in places, records were incomplete. This meant that the temporary staff supporting people may not have access to the information they require to support people in the way they would like.

Relatives we spoke with knew how to make a complaint. One relative told us, "I would always go to the person who is on shift if I wanted to complain". A relative told us that they had previously made an informal complaint and that the manager had resolved the issue straightaway to their satisfaction. Staff knew the action they should take if someone wished to make a complaint. One member of staff said, "I would make the team leader and manager aware. We have got paperwork for people to fill in if they want to make a

complaint". The manager had not received any complaints but could identify how they would investigate any that arose. The manager told us, "I would record [the complaint], see what the nature of it is and can I rectify it". We did not see any information displayed informing people of how they can complain in a way that would support them to understand how complaints can be made.

Requires Improvement

Is the service well-led?

Our findings

We saw that a number of Deprivation of Liberty applications had been made by the manager. Some of these had been authorised. The manager had not notified us of these authorisations as is required by law. Providers have a legal responsibility to inform us of any authorised Deprivation of Liberty applications. This meant that the provider was not meeting the legal requirements of their registration with us.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The manager told us that they identify staff training needs by requiring the staff to complete self-assessment forms, rating their knowledge in different areas.The manager told us that they undertake competencies in medication to identify any training needs in this area. We saw that staff had received training to support them. However, the manager had failed to identify that staff did not have an awareness of who required a DoLS and how they should support people with DoLS authorisation in place. The manager had also not identified that new staff did not have the skills or knowledge required to support people displaying behaviours that challenge. Records we saw about people's care needs that could give staff this information were not personalised and were incomplete in places. This meant that systems to assess and monitor that staff had the skills and information needed to support people were not effective.

We saw that the manager completed quarterly quality assurance audits. The audits looked at areas including infection control, catering and medication. We spoke with the manager about the medication errors we had identified. The manager told us they had identified these mistakes and had raised this with the suppliers of the electronic medication system as she believed they were the result of a technical fault. However, no further action had been taken to reduce the risk of further errors whilst the suppliers looked into this issue. This meant that the risk of medication recording being inaccurate in future had not been minimised and we saw that further errors had occurred since the manager's audit. The audits had also failed to identify that people were not being supported to make choices about what meals they would like and the lack of structure around mealtimes.

We saw that the manager sought feedback from relatives in order to make improvements in the service. This was done via questionnaires and relatives meetings. We saw that a questionnaire was sent in December 2015. The comments made were all positive. We saw that there was information displayed about a 'managers surgery' held once a month in which people could arrange to discuss any issues with the manager. Relatives spoken with had not used this service but told us they were comfortable in approaching the manager with concerns.

The deputy manager of the home was responsible for the running of the home as there was no registered manager in place. Recruitment was ongoing for a new registered manager. Relatives spoke positively about the leadership at the home. One relative said, "If they can do something to help you, they will". Staff we spoke with also felt supported by the deputy manager. One staff member told us, "I do feel supported, you can ask them anything and they will help you and pitch in". We saw that the deputy manager had a visible presence around the home and took time to speak with people. We spoke with the deputy manager about

how they were supported to manage the service in the absence of a registered manager. The deputy manager told us that the provider's area manager would visit the home once a week to provide support in the managing of the service. The deputy manager told us that this was sufficient support to enable her to do the role. Staff we spoke with were aware of the leadership structure and knew who they were to report to.

We saw that staff felt confident to raise concerns and knew how to whistle-blow if required. One member of staff told us, "I could raise concerns with the manager and she would do the best she could". Another member of staff said, "If I raised a concern, she would act on it".

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 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 18 Registration Regulations 2009 Notifications of other incidents The manager had not notified us of Deprivation of Liberty authorisations. Providers have a legal responsibility to inform us of any authorised Deprivation of Liberty applications. This meant that the provider was not meeting the legal requirements of their registration with us.