# Woodland Healthcare Limited

# Woodland Park

## Inspection report

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16 August 2016

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## Ratings

| Overall rating for this service | Requires Improvement |
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| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

Woodland Park is a large detached nursing home situated in Babbacombe, near Torquay in Devon. It is registered to provide personal and nursing care for up to 25 older people. An unannounced inspection took place on 12 and 16 August 2016. At the time of the inspection there were 19 people living at the service with a mixture of residential and nursing care needs.

We had previously inspected the service in May 2013 when we found the service was not meeting requirements in relation to records. When we checked in October 2013 we found the necessary improvements had been made and the service was compliant with all regulations. Prior to this inspection we had received information about a safeguarding matter that was being looked into by the local authority safeguarding team.

The service had a registered manager who worked across two registered services and spent half their time at each. 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.

Although staff were knowledgeable about people's needs, we found people were at increased risk because staff did not have access to detailed, clear care plans about each individual's care and treatment needs. Documentation about people's care needs was fragmented. This made it difficult to see how risks were being managed as there was no clear pathway between the identification of risk through to the plan of care needed to manage the risk. Some people's risk assessments and care plans did not contain accurate or up to date information or reflect the care they were receiving and there were gaps in some people's records. For example, we found that records for the application of prescribed creams were not always being kept accurately. This meant the manager or nurses could not tell if people were receiving all of their prescribed medication correctly and people could be placed at risk of skin damage. However, we saw no evidence of skin damage this during the inspection.

The service had enough staff to support each person's individual care needs. We saw staff sitting and talking to people and people being assisted unhurriedly. This indicated there were enough staff on duty to meet people's needs.

People and their relatives told us staff were skilled to meet people's needs and spoke positively about the care and support provided. One person told us "I'm very well looked after by the girls" One family member told us staff knew their relative's care needs very well and commented "they are really on top of [name of relative's] care. Staff here are wonderful really". Staff were experienced and had the skills and knowledge to provide care for people living at the service. They undertook regular training relevant to the needs of the people they supported. Staff demonstrated awareness of safeguarding and understood their responsibility to report concerns. People were relaxed and comfortable with the staff supporting them. This indicated they

felt safe.

Accidents and incidents were reported and measures were taken to reduce risks for people.

People were offered day to day choices and staff sought people's consent for care and treatment. Mental capacity assessments were not always completed in line with the legal process set out in the Mental Capacity Act (MCA) 2005 Code of Practice. This meant people's rights may not be fully protected.

The home arranged for people to see health care professionals according to their individual needs. Staff worked closely with local healthcare professionals when necessary. A health professional said their experience was that staff sought advice appropriately and communicated well about people's health needs.

The culture of the home was warm and friendly and people told us they felt safe and were supported by kind and caring staff. One person said, "They [the staff] are all wonderful and very kind to us" and another said "We have a lot of fun here and I am happy". We observed staff being kind and respectful to people, as well as sharing jokes and general conversation. Staff told us they enjoyed working at the home and they received a great deal of satisfaction from caring for people. One said, "I enjoy making them laugh, sharing their problems and being part of their last years. I want to make it as dignified and important a time as the rest of their lives".

We looked at how people were supported to follow their interests and take part in social activities. People who were able to engage in formal activities told us they enjoyed what was provided, but would like to do more. Some people said they felt bored and some relatives told us they had noticed a reduction in the number of activities available. There were no specific activity plans in place to guide staff about how to support people's social needs and maintain their individual interests. This meant people who found it difficult to engage or preferred to remain in their room through choice or health reasons could be at risk of social isolation. We spoke with the registered manager about this who said staff had time to chat to people in their rooms. However, feedback from people and staff did not support that this always happened. The registered manager told us they were in the process of recruiting a new activities coordinator and developing this aspect of the service. We have made a recommendation about the provider seeking advice and guidance about supporting people at risk of social isolation with engagement in meaningful activity and stimulation.

People were involved in developing and reviewing their care plans assisted by staff, relatives or others who knew them well. Staff knew people well and cared for them as individuals. They were aware of what mattered to people, about people's lives their families and their interests. People were encouraged and supported to maintain relationships with their relatives and friends and to make new friendships within the home. Visiting times were not restricted and relatives and friends were welcome at any time.

People were supported to maintain their health through good nutrition. People told us they enjoyed the meals provided by the home, describing them as "tremendous" and "very satisfactory". They said they could have drinks and snacks whenever they wished and always had a good level of choice. People's nutritional needs and food preferences were recorded in their care records and in the kitchen so that the chef had easy access to this information. We saw people being assisted with their meals at breakfast and lunchtime. Staff sat beside each person who required support and helped them to enjoy their meal at their pace.

The provider had a complaints policy. People and relatives said they could to speak to staff or registered manager about any problems and felt confident they would be listened to. The service was working with families and the local authority to resolve two complaints at the time of our visit.

People, relatives and staff were confident in the leadership of the registered manager. One person said "I could tell [registered manager's name] anything. I like her. She keeps everything on track". Staff said they received a good level of support through supervision and could ask for guidance or support whenever they wanted.

There was a clear management structure within the home. The registered manager worked across two locations and spent half their time at each home. They also held additional responsibilities in relation to providing quality monitoring of another home in the Woodland Healthcare group. They told us they were well supported by the deputy manager and by the director of Woodland Healthcare, but were very busy working across both homes. They told us they believed the service would benefit from full time management support and were in the process of seeking a suitably skilled and competent manager to assist with the running of the home.

The provider had a range of quality monitoring arrangements in place to monitor care and plan ongoing improvements. This included audits, surveys and regular health and safety checks. These checks were not fully effective as they had not recognised the issues we found during our inspection. The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC) and was aware of their responsibility to their duty of candour. The duty of candour places requirements on providers to act in an open and transparent way in relation to providing care and treatment to people.

We identified breaches of regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

## 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**

Some areas of the service were not safe:

Poor record keeping placed people at potential risk of harm.

People were at risk of not receiving their prescribed creams correctly because recording systems were not robust.

People were protected from the risk of abuse through the provision of policies, procedures and staff training

People were supported by sufficient numbers of safely recruited and well trained staff.

### Is the service effective?

**Requires Improvement**

Some areas of the service were not effective:

People's legal rights may not be fully protected because mental capacity assessments or best interest's decisions were not always completed in line with legal requirements.

People's nutritional needs were assessed to make sure they received a diet that met their needs and wishes.

People were supported to have access to health professionals including GP's, district nurses and physiotherapists to help them have their health needs met.

### Is the service caring?

**Good**

The service was caring:

People's needs were met by staff with a caring and warm attitude.

People lived in a home that was relaxed and welcoming and were supported to receive visitors whenever they liked.

People's right to privacy and dignity was respected.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive:

People were not all supported to engage in activities of their choice. The registered manager told us they intended to take steps to address this.

People received personalised care that was responsive to their needs.

People told us their choices were respected.

People and relatives felt able to speak out if they had a concern and that their complaint would be dealt with.

## Is the service well-led?

**Requires Improvement**

Some areas of the service were not well led:

People's quality of care was always not protected or assured by effective monitoring systems.

People benefitted from a service that had a registered manager and a culture that was open, friendly and welcoming.

People and relatives' views were sought and taken into account in how the service was run.

People and relatives had a high level of confidence in the registered manager.

# Woodland Park

**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 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over two days on 12 and 16 August 2016 and was unannounced. It was carried out by one adult social care inspector and a specialist advisor (nurse) on the first day and one social care inspector and an expert by experience on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at the information we held about the home. This included previous contact about the home, safeguarding concerns and notifications we had received. A notification is information about important events which the service is required to send us by law. We saw there was a safeguarding matter being looked into by the Local Authority safeguarding team, which had not yet been concluded.

During the inspection we met with everyone living at the home and spoke with 11 people. We also spoke with the registered manager, two registered nurses, four care staff, the administrator, two cooks, a housekeeper, maintenance staff and five relatives. We spoke one health care professional who had regular contact with the home.

We looked around the premises, spent time with people in the communal areas and observed how staff interacted with people throughout the day, including how people were assisted with their meals and how people were assisted to move. We looked at five sets of records relating to people's individual care needs; three staff recruitment files; staff training, supervision and appraisal records and those related to the management of the home, including quality audits. We also looked at the way in which medicines were recorded, stored and administered to people.

Requires Improvement

# Is the service safe?

## Our findings

During our inspection we observed staff providing care of a good standard. However, this was not supported by the documentation and record keeping at the service, which was inconsistent in quality and detail. This meant risks were increased for people because we could not be assured from reading the records that people's care needs were being fully met or that identified risks were being managed.

Risks to people's safety and well-being were assessed prior to their admission to the home and were regularly reviewed to identify any changes in people's care needs. However, these assessments did not lead to care plans that were sufficiently detailed to guide staff about how to meet people's care needs and manage risks. For example, one person was nursed in bed and had a significant risk of developing pressure sores. Risk assessments had identified the need for regular repositioning and application of prescription creams to protect their skin from this damage. The care plan said "I have my pressure areas checked whenever my incontinence pad is changed and my position altered". Care staff and registered nurses told us repositioning was completed every two hours and a relative confirmed this happened regularly. However, there was no detailed guidance available within the plan about the frequency of repositioning. The care plan also said "the air pressure in my mattress is worked out from my weight", but did not include information about what that weight was. Another person, who had care needs in relation to their continence, had a care plan which said "change pad when needed". There was no guidance for staff about the frequency with which this should occur. Whilst we did not see any negative impact for people, lack of detail about people's care and treatment needs in their records increased the risk they would not receive the care they needed in a safe way.

Documentation regarding risk assessments and care plans were fragmented with information held in a variety of documents. All pre-admission assessments used a standard approach commonly used in nursing care, giving attention to areas such as people's safety and mobility, communication and dietary needs. This led to more detailed risk assessments in areas such as falls, pressure area care and choking risks. The format used for care planning and risk assessments did not clearly present areas of care required. For example, for one person who was at risk of developing pressure sores, information was presented in three different sections of the care plan relating to pressure area care, rather than one. It was therefore difficult to follow a clear pathway from the identified risk through to the care that needed to be provided to manage the risk. This did not give staff clear guidance about the care they needed to provide.

Risk assessments and care plans did not always reflect people's up to date care needs. For example one person's risk assessment and care plan said they could sometimes get out of bed with assistance of two care staff and a zimmer frame, but on 'bad days' a hoist should be used. There was no guidance for staff about how to judge when a hoist should be used. We asked staff about how they supported this person to move safely. They said they no longer considered it safe to use a hoist at all. This was because this person's needs had changed over recent months and the person became so distressed when being hoisted they were at high risk of slipping or hurting themselves. This showed care records were not accurate or up to date.

We spoke with staff about how they were provided with information about people's care needs and found

that although they were aware of care plans, they took their guidance mostly from verbal handovers and from the nurse on duty. Care records were locked in the treatment room and were not easy accessible to care staff. There was an expectation that staff made a daily record in people's files to reflect the care they had received during the day and overnight. This contained little detail of the actual care delivered and in some cases there were omissions in people's records where no entry had been entered for several days. Staff told us they kept separate charts to record some areas of care for people which were kept in the manager's office. This included repositioning of people whose skin was vulnerable to becoming sore and records of creams applied to help protect people's skin. We reviewed these records and found significant gaps in recording. This meant that it was not possible to tell from reading the daily records or charts whether or not the required care had been provided in line with people's care plans or whether people had been repositioned as they should.

We looked at how medicines were managed within the home and as part of this, considered management of prescribed creams. Creams are an important aspect of keeping people's skin healthy, particularly for those people with continence needs. Registered nurses told us they recorded that creams had been applied by marking a 'c' on the medication administration records. This indicated it had been completed by care staff. However, the medication administration records completed by nurses did not match with the charts completed by care staff, where there were significant gaps in recording. This meant nurses were signing on behalf of care workers for care they did not carry out and could not be sure had been completed. Nurses retain responsibility for the administration of all medicines, including creams. However, records did not demonstrate whether there was registered nurse oversight into people's essential care interventions. We could not be sure from the care records that people were getting their prescribed creams as they should.

These issues were a breaches of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014

Other aspects of people's medicines were managed safely. Medicines were administered by the registered nurse on duty. They gave people their medicines in an unhurried way and took time to explain to people the purpose of each tablet. People knew about their medicines and were clearly familiar with this process. They were offered choice about whether they needed their 'as required medicines', such as pain relieving medicines and laxatives. The nurse knew people's preferences about how they liked to take their medicines. For example, one person did not like the nurse to 'stand over' them while taking medicines. The nurse left tablets beside them and then discreetly checked they had been taken a couple of minutes later. The nurse wore a tabard whilst giving medicines, reminding other care staff not to disturb them. This reduced the chance of any errors whilst administering medicines.

Medicine administration records were clearly signed with no gaps in the recordings. The medicine administration records included information which protected people, such as any allergies, or any special instructions such the placement of medicated patches. Where medicines were prescribed with a varying dose, such as warfarin, this was managed safely. For those people who were unable to express their needs, a pain assessment record was used to assess if they appeared to be uncomfortable, enabling the nursing staff to provide pain relief. Anticipatory medicines were requested from the person's GP when they were identified as nearing the end of their life to manage their symptoms. These medicines helped people to experience a pain free and dignified death. Medicines were stored safely and only the nurses had responsibility for checking stocks, reordering and disposing of medicines no longer in use. Registered nurses and the registered manager undertook monthly audits to ensure records had been accurately completed and the medicines received in to the home and administered could be accounted for. However, this had not identified the issues with prescribed creams mentioned earlier in this report. We checked the quantities of a sample of medicines against the records and found them to be correct. We saw medicine that required

refrigeration was kept securely at the appropriate temperatures.

On the first day of our visit we entered the home through an open door which led directly onto the car park area and was close to a busy road. On the second day of the inspection, this door was again open. The weather was warm and the open door provided a welcome breeze. There were plenty of staff about during the inspection and it would be unlikely for someone to enter or leave unseen. However, there was a potential risk to people's safety, their belongings and to the security of the building. We have asked the registered manager to give this their consideration.

People told us they felt safe living at the home and with the staff who supported them. They said staff treated them kindly and they felt safe with them. Comments included: "They are so kind here", "It's lovely in here" and "of course I feel safe". Where people could not express their views clearly, they appeared relaxed and comfortable with staff. Relatives also felt people received safe care and attention.

Staff had received training in safeguarding adults. They knew how and to whom they should report concerns. They said they felt confident any concerns would be dealt with promptly by the registered manager and they were confident no member of staff would tolerate anyone receiving poor care or being abused. The policy and procedure to follow if staff suspected someone was at risk of abuse was available in the office. Contact numbers for the local authority safeguarding team were well displayed in the office and in the entrance foyer. Two safeguarding matters were underway at the time we inspected and records were being kept in relation to these with communication between the registered manager and the local safeguarding team.

Not all staff we spoke with were aware of whistle-blowing procedures, whereby they could report any concerns to external agencies such as the CQC 'in good faith' without repercussions. A poster in the entrance foyer encouraged staff, relatives or people living at the service to report any whistleblowing concerns to an independent investigator. A separate poster gave CQC's contact details. We spoke with the registered manager about this at the time who told us they were confident training about whistleblowing had been provided to all staff, but they would revisit this at the next staff meeting to make sure all staff knew they could report any concerns directly to CQC or other external agencies.

The provider had a policy of not managing monies on behalf of people who lived in the home which reduced this risk of financial abuse. Everyone had a lockable drawer in their bedroom where money could be kept if they wished.

There were safe recruitment practices in place to ensure, as far as possible, only suitable staff were employed at the home. We looked at three staff recruitment files, all of which held the required pre-employment documentation including proof of identify, references and Disclosure and Barring (police) checks. Records showed the registered nurses had their registration with the Nursing and Midwifery Council checked prior to their employment and then every three months.

People and staff told us there were sufficient staff on duty to keep people safe and meet their needs. They said their call bells were answered promptly and we observed that this was the case. One person said "I think the staff levels are fine". Another told us they had once fallen in their room "and a carer came straight away and called the paramedics". Another person told us they could have a drink during the night if they wanted: "I ring the bell. If I want something I ask". We observed that staff were unhurried in their interactions with people and spent time talking with people. One person's call bell was out of reach after their room had been cleaned. We spoke with the registered manager about this who dealt with it immediately. They said they would remind all staff about the importance of everyone having their call bells within reach.

The registered manager told us staffing levels were arranged in accordance with people's care needs which were regularly assessed to identify changes in their dependency and their possible need for more assistance from staff. They told us the care needs of people living at the service at the time of inspection were lower than usual; two people were in hospital, one was on holiday and eight people had residential care needs. Staffing levels at the time of the inspection were the registered manager, a registered nurse on duty and four members of care staff. An additional member of staff helped over the busy breakfast period; bringing people their breakfast and helping with delivering laundry back to people's rooms. There were a range of ancillary staff including two housekeepers, two chefs and a maintenance worker. At night time there were two care staff and one registered nurse, referred to as the 'peri' (peripatetic) nurse. The registered manager explained that the peri nurse role had been introduced in response to the national shortage of registered nurses working in the care sector. They provided nursing cover between three of Woodland Healthcare Limited's homes that were all in close proximity to each other. The peri nurse was backed up by a second registered nurse who was on call and could come to any of the services if there was an emergency or additional support was required. The registered manager told us that this system of providing nursing cover was working well. A monthly audit was completed that included reporting on peri nurse activity and this was shared with the local council commissioning team to assist with monitoring effectiveness.

People had equipment in place to help reduce risks. For example, where people needed the use of a hoist to assist them move safely, they had their own slings which were clean and easily accessible in their rooms. People at risk of developing pressure sores had pressure relieving equipment such as mattresses and pressure relieving cushions in place. Nurses also completed a daily visual check of each person's skin where there was a risk of skin becoming sore or broken.

We observed moving and handling practice being completed safely and confidently by care staff. People told us they felt safe while staff were assisting them, for example, when using a hoist. Staff spoke reassuringly to them throughout the process and were unhurried in their approach.

Accidents and incidents were reported. Each accident was reviewed by the registered manager to identify whether additional steps could be taken to reduce the risk of recurrence. Where a person had a fall or was identified at higher risk of falling, there was attention to any additional steps that could be taken to minimise the risk. For example, by wearing good fitting footwear and through the use of mobility aids. People were referred to the community 'falls' team and to relevant therapists such as occupational therapists and physiotherapists where additional support was required.

Each person had a personal emergency evacuation plan showing what support people needed to safely evacuate the building in the event of a fire. An emergency box was stored by the front door with necessary equipment and information to support people should people need to be evacuated. For example, blankets, torches and contact numbers. The premises and equipment were maintained to ensure people were kept safe. Equipment was regularly serviced and tested as were gas, electrical and fire equipment. Weekly checks of the fire alarm system, fire extinguishers, smoke alarms, and fire exits were undertaken. A member of maintenance team said, "I want to see these people safe. It matters to me that I do everything I can, otherwise I wouldn't be able to sleep at night".

There was an ongoing programme of repairs, maintenance and refurbishment to improve the environment of the home. People were cared for in a clean, hygienic environment. One relative said the home always smelled nice and that was an important factor for them. Staff had access to hand washing facilities and used gloves and aprons appropriately. Housekeeping staff had suitable cleaning materials and equipment available to use. Soiled laundry was appropriately segregated and laundered separately at high temperatures in accordance with the Department of Health guidance.

Requires Improvement

# Is the service effective?

## Our findings

Many people living at Woodland Park had the mental capacity to be able to consent to live in the home and receive care. However, some people were living with dementia which affected their ability to make decisions about their care and support. We checked whether the service was working within the principles of the Mental Capacity Act (2005) and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff told us they had received training in the Mental Capacity Act 2005 (MCA) and understood the principle of people being able to make their own choices and decisions about their care wherever possible. The Act 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Where best interests' decisions are reached, these must be made involving people who know the person well, including family and health and social care representatives where relevant.

We saw that for some people, mental capacity assessments were being appropriately completed. However, documentation was inconsistent in quality and did not always meet the clear guidance set out within the MCA Code of Practice. For example, some mental capacity assessments were not decision specific or had not been completed. Records for one person contained a mental capacity assessment where no decision had been identified and no best interests' process had been followed. However, the mental capacity assessment contained a statement saying "It is deemed in her best interests to have all personal care needs met at least once a day". There was no evidence of correct legal process for reaching this decision having been applied. This meant people's legal rights were not fully protected because not all care staff had a full understanding of the requirements of the MCA.

We spoke with the registered manager about this and they told us that people's mental capacity assessments were completed by either the registered nurses or themselves. The registered manager acknowledged that there was some variation in care staff's levels of understanding and this was being addressed through the training programme.

We recommend that the service seeks training from a reputable source in relation to the Mental Capacity Act (2005) to ensure knowledge and practice is up to date for all staff.

Correct practice had been followed in relation to applications for Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect people's rights to their freedom and liberty and require authorisation from the local authority to restrict liberty should that be necessary to keep people safe. At the time of our inspection, four applications had been made for people where they were unable to consent to being in care, received continuous supervision and would be at risk if they left the home unsupervised. Due to the number of applications being processed by the local authority, the service was still waiting for these

assessments to be completed.

The registered manager was aware of current criteria for applying for DoLS and was able to discuss this with us. They told us they remained unclear about one person's capacity to consent to receiving care and treatment, due to the degree of their communication difficulties. They were seeking input from external professionals to access equipment to aid communication and enable the assessment to be completed. Whilst awaiting that, a DoLS application had been made as a protective measure. This was good practice.

People's right to refuse care where they had mental capacity to do so was understood and respected by care staff and the registered manager. Staff told us that, whilst they knew people had the right to refuse, they would always explain to people any risks that might to be attached to their refusal. For example, where somebody's skin might become sore if they declined to have their skin washed. We saw evidence of good practice in one person's records where refusal to accept pressure relieving equipment could lead to skin damage. The registered manager had considered this person's mental capacity on two occasions to make this decision and found no reason to doubt their mental capacity. There was documented evidence that risks had been discussed with the person on two separate occasions. Family members had been involved in these discussions. The registered manager was aware they should continue to review this situation and had sought the views of external professionals, such as the district nursing service in assessing that this was the correct approach.

People and their relatives told us staff were skilled to meet people's needs and spoke positively about the care and support provided. One person told us "I'm very well looked after by the girls" One family member told us staff knew their relative's care needs very well and commented "they are really on top of [name of relative's] care. Staff here are wonderful really"

Staff told us they were well supported in their role and received appropriate training and professional development. For example, care workers told us they had completed training and updates in areas such as fire safety, moving and transferring people safely, infection control, safeguarding and the Mental Capacity Act (2005). Other training courses were available to ensure care workers were able to meet the specific care needs of the people who lived in the home. These included dementia, catheter care, person centred care, skin care and end of life care. A pharmacist provided monthly training about specific areas of medicines management, such as safe storage and disposal of medicines.

We saw care workers completed a comprehensive induction programme that took account of nationally recognised standards within the care sector. Newly employed staff members were required to complete an induction programme and were not permitted to work unsupervised until they had completed this training and had been assessed as being competent to work alone. All care staff were either completing national diplomas in social care or were enrolled to undertake the Care Certificate. This certificate is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support.

Care staff told us they felt supported in their learning by the registered manager and deputy manager. They said they felt able to approach the registered manager if they needed to discuss anything or had a specific question. They also received regular supervision and annual appraisals where different topics were discussed. One member of care staff said they had been encouraged to develop professionally by the registered manager who was supporting them to work part time whilst completing an access to nursing course. They were hopeful this would lead onto completing a degree in nursing. Different topics were also discussed during staff meetings to aid care staff's learning and understanding. For example, a recent meeting topic had been about the 'duty of candour' and everyone's responsibility to act in an open and

transparent way and acknowledge and learn from any mistakes that were made. Staff said they found these meetings useful.

People told us they enjoyed the meals provided by the home. One person said "The food is tremendous. I can choose any food. I like fish and chips." Another said "the food is very satisfactory". We saw people enjoying fish and chips on one day of our visit and chicken and mushroom pie on the other. Where they did not like this option, they had a range of alternative choices including baked potatoes, omelettes, pasta, scampi and chips and cottage pie. People were asked for their menu choice the evening before, but could change their mind at any point and make an alternative choice. We saw one person requesting scampi and chips instead of the main option on one day of our visit and this was accommodated happily. There were also choices available for breakfast and evening meals. The chef told us they had good resources available to them and used quality fresh meat and vegetables to prepare meals with. Any specific dietary needs were recorded on a board in the kitchen. For example, where people needed food to be a particular consistency or where they had particular likes and dislikes. People's food preferences were also recorded in their care records and staff were aware of everyone's particular likes and dislikes.

The weather was hot on both days of our inspection. We saw jugs of squash or water were available in everyone's room and people had drinks within reach. In the afternoon staff were offering people cold drinks including lemonade and shandy, which people clearly enjoyed. We saw people being assisted with their meals at breakfast and lunchtime. Staff sat beside each person who required support and helped them to enjoy their meal at their pace. Staff asked people what they would like and ensured it was to their taste while they were eating. Staff told us if somebody wasn't enjoying their food, they would offer something else. The registered manager told us they believed food and nutrition was a vital part of maintaining people's health and quality of life and that it was an area of care the service prided themselves in.

The home arranged for people to see health care professionals according to their individual needs. Records were kept of referrals to GPs, community nurses, mental health professionals and other health care specialists such as occupational therapists or the speech and language teams for people with swallowing difficulties. The outcomes of these referrals were documented in care records. We saw staff were observant to changes in people's health. For example, one person had been coughing whilst they were eating their breakfast on the first day of our visit. On the second day we saw that GP advice had been sought and a thickener had been prescribed for this person's drinks. A referral had also been made to the speech and language therapist team. People who had residential care needs, when necessary, received support from the community nursing service, for example with monitoring and dressing any areas of sore or broken skin.

The community nurse we spoke with during the inspection said their team visited infrequently, as Woodland Park was a nursing home. However, when they did visit, they found care staff communicated well and were well informed about people's care needs. Staff were always available to feedback to and the registered nurse was available when needed.

We considered whether people's needs were met by the adaptation, design and decoration of the service. The building was well maintained. It was decorated and furnished in a modern, bright and homely way. One bathroom had recently been converted into a large wet room to enable easy access for people. The home had limited outside space. We were shown a grassed communal garden area that was surrounded by a low hedge and not easy to access. Staff told us this was rarely used. A table and chairs were available at the front of the home and two benches. Staff told us several of the men who lived at the home usually liked to sit chatting at the table, but they were away at the moment. Although we observed limited outside space, this was not raised as a concern by any of the people we spoke with.

Good

# Is the service caring?

## Our findings

People said they were supported by staff who were kind and caring. One person said, "they [the staff] are all wonderful and very kind to us". Another said "We have a lot of fun here and I am happy". One person had their birthday in the week before our visit. They said staff had made them feel special: "I had a big party with special things to eat and my friends came and we had a nice day". Relatives also told us they felt the staff were very kind and caring. One relative said "Staff are so comforting the way they talk to people. All very loving and caring towards people. They are all great". Another told us "[name of nurse] is really caring. She has a special affinity for Mum; it's like she is part of her real family".

We reviewed a selection written compliments recently received by the home. These showed a high level of satisfaction with the care and support provided by the staff. For example, one card said "Thank you for making [name of relative]'s final days so comfortable with your kindness and support, which extended out to me every time I visited. We appreciated the music in the background. It made the room less lonely and was his favourite style of melodies". Another said "Staff were always kind, caring and above all, loving towards Mum which I feel improved her quality of life at a difficult time".

Staff were very kind and respectful to people, we observed them sharing jokes, in general conversation and offering comfort when needed. They were skilled at recognising people's moods and interacting with people based on this. For example, we saw one person having great fun laughing and chatting with care staff about a visit they had at the weekend from a Mickey Mouse party character. Another person had recently moved to the home and staff took time to draw them into conversation with other people sat in the dining room and make them feel comfortable. Friendship groups were encouraged and staff took time to make sure people were sitting together when they wanted to be. One person told us "I enjoy it here. There are people my own age, the same generation and we interact with each other". One person had suffered a stroke which caused them to easily become emotional. We observed care staff giving this person their lunch. As it was placed in front of them they started to cry, but the staff member had a box of tissues ready held under the lunch tray, in anticipation of this. They said "I have them ready to go for you, extra soft". The person smiled and said to us "she is brilliant".

Staff told us they enjoyed working at the home and they received a great deal of satisfaction from caring for people. One said, "I enjoy making them laugh, sharing their problems and being part of their last years. I want to make it as dignified and important a time as the rest of their lives". Another said "I love my work. Love the people. The way I see it, it's like I leave my home in the mornings and come to work at my other home. We are like another family"

Care staff told us they supported people to remain as independent as possible and encouraged people to take part in their care as much as they could manage. For example, by shaving or brushing their teeth or eating without assistance. We saw evidence of this during our visit. For example, staff offered to cut food up for people to make it manageable for them to eat independently. They encouraged people to walk and accompanied them in an unhurried way, praising them and offering gentle reminders. One member of care staff talked about encouraging people to continue to eat independently and said "If it goes cold we can

always heat it up or get something else. What does it matter? It's much more important residents keep their skills and we don't take over".

People's privacy and dignity were respected. Staff asked people beforehand for their consent to enter a room or provide any care and doors were always kept closed when personal care was being offered. We saw staff ensuring one person had a blanket over their legs to preserve their dignity while they were being assisted to move using a hoist. Staff were discreet when asking people if they wished to use the toilet. The home had a member of staff who was an appointed 'dignity champion' and the topic was discussed through staff meetings to ensure staff remained well informed. Care plans contained information for each individual regarding how to uphold their self-esteem and dignity. For example: "staff ensure my door is closed and my body kept covered during my ablutions" and "give me the choice about what to wear".

The home had a calm, relaxing and homely feel. Everybody's room was personalised with ornaments and photos personal to them and people could bring their own furniture if they wished. One person told us how much they liked their room. They said, "I have a lovely room, I can see the trees". People made choices about where they wished to spend their time. We heard staff asking people if they would like to eat their meal in their room or the dining room. There were no locked doors and people could come and go from the home as they wished, though most preferred to stay in. People were encouraged and supported to maintain relationships with their relatives and others who were important to them. Visiting times were not restricted and relatives and friends told us they were always made to feel welcome and offered a drink.

There were ways for people to express their views about their care. Each person had their care needs reviewed on a regular basis which enabled them to make comments on the care they received and view their opinions. If they were unable to express their views, their family was involved where relevant. Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way and with genuine fondness for people.

The home was able to support people's care at the end of their lives. The registered manager told us they felt the service excelled in this area and had good relationships with the local hospice. We saw a small number of people were being cared for in bed due to poor health and all appeared comfortable and pain free. Anticipatory medicines were requested from the person's GP when they were identified as nearing the end of their life to manage their symptoms. These medicines helped people to experience a pain free and dignified death. There were many cards from grateful relatives thanking staff for the sensitive care provided at the end of their loved one's life.

Requires Improvement

# Is the service responsive?

## Our findings

Whilst we found people received care that was responsive to their needs in most areas, improvement was needed in relation to supporting people to maintain their social interests and activity.

During our inspection we looked at how people were supported to follow their interests and take part in social activities. People told us they enjoyed the activities that were available, but they would like to do more. Some said they felt "a bit bored". Another said "I don't do a lot". Others told us they liked to stay in their rooms and read, or do the crossword, watch television or listen to music. Relatives noted there were now fewer activities available than there used to be and they thought there should be more. We saw people sitting in the lounge area participating in an interactive music and dance session, which they greatly enjoyed. These people also benefitted more generally from the stimulation provided by staff and visitors who were in and out of the lounge area throughout the day. A lunch club took place on most Sunday's, which was proving popular. One person told us "I love it!" People dressed up and enjoyed food and drink and conversation and family members were welcome to join in. Staff told us they used particular objects to stimulate conversation; recently this had been a wartime cookery book and people had talked about their memories of the war period, what they ate and sang songs from that time. Again, this activity was one that benefitted the same group of people who sat in the lounge area.

We asked staff and the registered manager about how people, who found it difficult to engage or preferred to remain in their room through choice or health reasons, were supported to socialise and maintain their individual interests. We noted there were no individual activity plans in people's files (although information was held about their interests) and daily records did not give an account of how people spent their day meaningfully. The registered manager told us staff had enough time to spend individually with people in their rooms while they were providing care. However, people told us staff did not always have time to spend talking with them. One person said "They just pass a few words. They are very busy". Another said "[staff] chat to me when they have time, but they are very busy". There were mixed views from staff about this. Some felt they had enough time to spend with people, whereas others said they needed more time: "Sometimes we are very busy. We don't have time to provide 1:1 or take people out ". We spoke with the registered manager about this and they acknowledged that providing activities was an area needing further development. They explained they had recruited an activities coordinator but they had stayed for only one week. They planned to rethink their approach to activities and implement a more person-centred approach once a new activity coordinator had been appointed.

We recommend the service seek advice and guidance from a reputable source, about supporting people at risk of social isolation with engagement in meaningful activity and stimulation.

People were encouraged to express their views and be involved in making decisions about their care and support. People confirmed they had been consulted about their care needs, both prior to and since their admission and asked how they wished to be supported.

Care staff told us they enjoyed getting to know people and developing an understanding of everyone's

individual character and their preferences and this helped them provide care that was personalised. For example, one person who was living with mental ill health had moved in recently and staff had learnt they liked to remain in bed to eat their breakfast. In response to this the registered manager was arranging for a new bed that would support them comfortably while they were eating. One person had been admitted to hospital and staff realised they did not have any money with them. They knew this person did not like to be without change in their pocket and liked to have a magazine to read. The registered manager therefore took a small amount of money into them in hospital to enable them to buy a magazine.

Staff were able to describe in detail how they provided care to meet people's individual care needs and were knowledgeable about this. For example, where one person was sometimes resistive to receiving personal care, staff told us the strategies they used to encourage them to accept care. This included distraction techniques and leaving to try again later, or involving different care staff. We saw these techniques were described in the person's care plan.

People and their relatives were aware of their care plans and told us they participated in review meetings where care staff explained their care plans to them. Although care plans were not consistent enough in quality or detail to guide staff to manage some areas of risk, they were person centred; containing information to assist staff to provide care for people in a manner that respected their wishes. For example, one person was no longer able to verbally communicate their wishes, but staff had sought advice from their spouse about how they liked to be communicated with. The care plan commented "When you are carrying out my care, let me know what you are doing for me" and "I may appreciate a nice hand massage and some relaxing music". For another person, who was living with dementia, the care plan guided staff to talk about the day to day things they love – like the weather and what's going on that day. Also, to give them plenty of time to communicate their feelings.

Most people told us the routines within the home were flexible. For example, they could get up when they wished and eat their meals where they wished. However, some people said they felt they had to go to bed before the night shift staff came on at 8pm as this was more convenient for staff. They said they would sometimes like to go to bed later. We spoke with the registered manager about this. They were clear everyone should be able to go to bed when they liked. They told us they would talk to people and staff to make sure everyone's preferences were checked and met in this area.

People were supported to maintain and express their religious beliefs with members of the clergy visiting to provide communion on a weekly basis.

Care records included information about people's history, previous lifestyle, preferred routines and social interests. This provided staff with an insight into people's past lives, their hobbies and interests and their family life. Staff told us they did use this background information to inform their conversations with people while they were providing care. For example, one person had travelled extensively and collected shells and staff spoke with them about this and their travels.

People were aware of how to make a complaint and all felt they would have no problem raising any issues to the registered manager or other care staff. People we spoke with were very happy with the care they received. One person said "I have no complaints at all". Another said they "would tell one of the nurses" if they ever had a concern, but didn't have any. The complaints procedure and policy were accessible for people in the main entrance and on the back of everyone's bedroom door. Any complaints made were recorded and addressed in line with company policy. At the time of the inspection the registered manager was working with families and the local authority to resolve two complaints.

Most relatives told us they felt involved in their family member's care. However, one relative did not feel they had been listened to. They had requested they were involved in a particular aspect of one person's personal grooming, which was really important to them. However staff did not support this and act with sensitivity. We spoke with the registered manager about this and action has now been taken to resolve this.

Relatives told us there was a regular meeting where they could raise any issues, but they preferred to talk with staff or the registered manager at the time they visited to deal with any minor issues. One relative told us "I only have to say something and they tend to it". Another said: "I am able to talk with the nurse in charge if there are any problems, they are very approachable". The registered manager told us they would like to increase attendance at relatives meetings and were planning an evening with a meal available to encourage attendance and make it a sociable experience.

Requires Improvement

# Is the service well-led?

## Our findings

People and staff told us the home was well managed and the registered manager was open and approachable. Quality assurance systems were in place to monitor the quality of care and plan ongoing improvements. However, these systems were not always effective as they had not identified the risks and issues we found during our inspection, detailed previously in this report. For example, the home's policy was that medicines were managed safely and as prescribed and there was a system for auditing this. However, it had not identified the issues we found in relation to records and assuring prescribed creams were applied as they should be.

There was a lack of detail about people's care and treatment needs in their care plans, which increased the risk they may not receive care in a safe way. Documentation in relation to risk assessments and care plans was confusing and fragmented and did not present a clear pathway from the identification of risk through to the care that needed to be provided to manage that risk. Risk assessments and care plans were not always based on accurate and up-to-date information. Inconsistency in understanding and application of the Mental Capacity Act meant people's rights may not be fully protected.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014

There was a clear management structure within the home. The registered manager worked across two locations and spent half their time at each home. They also held additional responsibilities in relation to providing quality monitoring of another home in the Woodland Healthcare group. They told us they were well supported by the deputy manager and by the director of Woodland Healthcare, who maintained close contact and provided supervision and resources whenever needed. We observed they were exceptionally busy with calls coming throughout the day on the first day of our visit regarding the running of the sister home. They acknowledged their role was very busy and told us they believed the service would benefit from full time management support. They were in the process of seeking a suitably skilled and competent manager to assist with the running of the home.

There was an open and friendly atmosphere at the home. We saw the manager's office door was always open and people, relatives and staff regularly popped into chat, ask questions and raise any concerns. During the inspection, the registered manager was seen around the home, assisting and interacting with people, relatives and staff. Interactions were warm and had a sense of fun. Conversations between people and the manager were relaxed and well informed. This indicated the manager was in touch with people's care needs and well informed about their personal lives too. For example, we saw them responding to small details of people's care such as a prescription request for eye drops, as well as asking after people's families following visits.

The registered manager described the vision and culture of the home as "fun, loving and caring; that's how I want this service to be. And with no rules - it's their home, not mine." The registered manager told us they wanted to lead by example and they felt it was important to 'roll up their sleeves' and be able to do the job of any of the staff. We saw this was the case, with the registered manager being involved in a broad range of

activities through the day from providing care, to helping with serving lunches.

People and relatives were confident in the leadership of the registered manager. One person said "I could tell [registered manager's name] anything. I like her. She keeps everything on track". A relative told us that if they had a concern they would go to the registered manager: "If it was more serious I would get in touch with [name of registered manager], who has a heart of gold". Staff were positive about the support they received from the registered manager and deputy manager. They said there was good communication within the team and strong leadership. One member of staff said: "There is a lot of communication, we have regular staff meetings. If we mention something, it gets sorted". They felt valued by the service and this led to strong sense of loyalty and good staff retention amongst the staff team. No agency staff were used and staff were confident people benefitted from having an established staff team who understood people's care needs and personalities really well.

Supervision records showed management praised good practice as well recognising where staff members needed support with their learning or development. The registered manager told us they had invested great energy in developing a strong and happy staff team and they were proud of what they had achieved. Staff told us they felt part of a strong team and were confident in the leadership of the home. Staff received a good level of informal as well as formal support from the registered manager on a day-to-day basis. For example, we heard the registered manager giving clear instruction and regularly checking with staff about any concerns they had. Towards the end of the day they acknowledge everyone's hard work by buying chocolate for the staff team.

Essential information about each person and the day to day running of the home was effectively communicated between the staff team. Each day staff had a verbal handover meeting at the beginning and end of the day. New information about people's care, such as advice from visiting professionals or changed risk assessments, were shared. A daily diary was used to remind staff about people's appointments, report any concerns and supplies needed. Any maintenance actions required were written into a book specifically for maintenance staff. These were signed and dated when they had been completed.

The provider had a range of quality monitoring arrangements in place. Formal resident and relative and staff meetings were held on a regular basis. These provided people with the opportunity to discuss any concerns, queries or make any suggestions. Staff told us the meetings were useful and they were encouraged to share information about how to support people well and to make suggestions about the running of the home.

Quality surveys and monthly reporting were also undertaken on a range of issues including falls, compliments, complaints, safeguarding referrals and night time call outs by the peripatetic nurses. There was a training matrix to check staff kept up to date with training. The registered manager told us audits and checklists were used to monitor people's well-being, to ensure essential care tasks were not overlooked and to monitor the quality of the care and support provided. Accidents and incidents were monitored to identify any trends and patterns and where trends were identified, actions were taken to reduce risk. For example, in relation to falls. Monitoring of complaints had shown a consistent theme in relation to people's clothing going missing or getting mixed up. As a result of this the registered manager was introducing a new system where people's washing was completed in individual loads.

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC) and kept up to date attending training sessions and accessing professional websites. They were aware of their responsibility to their duty of candour, which places requirements on providers to act in an open and transparent way in relation to providing care and treatment to people. The registered manager had submitted notifications to us, in a timely manner, about any events or incidents

they were required by law to tell us about. They told us they kept in touch with best nursing practice by attending training events provided through Torbay and South Devon NHS Foundation Trust. They also attended care managers forums and said they had built strong networks with other care managers in the area. This had led to strong partnership working. For example, there was a reciprocal arrangement with another home that they would support each other in the event of an unforeseen emergency. Also, training events were shared to ensure as many care staff as possible had learning opportunities. For example Woodland Park was about to run a training event in respect of sepsis prevention and had invited staff from other care homes in the area to attend.

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<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Effective systems and processes were not in place to ensure action was taken to assess, monitor and manage risk.<br><br>Accurate, complete and contemporaneous records were not in place for each service user. Regulation 17 (a) (b) (c) |