Barchester Healthcare Homes Limited

Woodgrange

Inspection report

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Ratings

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

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection. During the inspection, we spoke with four people living at the home, four relatives, four nurses, one care staff, the registered manager and the chef. We also spoke with a visiting professional by telephone following our visit.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social care Act and associated Regulations about how the service is run.

Woodgrange provides accommodation and nursing care for up to 64 people who have nursing or dementia care needs. There were 59 people living at the home when we visited. Two of the people were not living there permanently. The home provides accommodation in two units. One of the units (Memory Lane) specialises in providing care for people with dementia.

People told us positive things about the service they received. People and their relatives said that they were very happy with the service. In addition, our own observations and the records we looked at supported this view.

People told us that they felt safe and well cared for. When we spoke with staff they were able to tell us about how to keep people safe. However we observed occasions when there were insufficient staff available to meet people's needs. For example when we carried out observations in The Memory Lane unit we found that during the second half hour of our observation there was insufficient staff available to meet people's needs.

The provider acted in accordance with the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). The provisions of the MCA are used to protect people who might not be able to make informed decisions on their own about the care or treatment they received. At the time of our inspection there was one person who was subject to DoLS.

We found that people's health care needs were assessed, and care planned and delivered to meet those needs. People had access to other healthcare professionals such as a dietician and a chiropodist.

People were supported to eat enough to keep them healthy. People had access to a range of snacks and drinks during the day and had choices at mealtimes. Where people had special dietary requirements we saw that these were provided for.

We looked at records of fluid intake and found there were gaps in the completion of the record which could put people at risk of not having sufficient fluids because accurate monitoring was not in place.

People told us that they felt their privacy and dignity were respected and made positive comments about staff. During our inspection we observed one occasion when we considered a person's dignity was not taken into account as staff were providing care to one person and talking about another. We saw that care took into account people's preferences.

Staff were provided with both internal and external training. In particular, staff told us that they had participated in dementia care training. The registered manager told us that all staff received an element of this training so that they were able to understand the needs of people with dementia. Staff told us they had received an induction when they started work with the provider.

We saw that staff obtained people's consent before providing care and were aware of how to respond if people refused care. People and relatives were aware of their care plans

Staff told us that they would usually raise concerns with the nursing staff rather than the registered manager as they knew them better. We found people and relatives were not consistently sure about the process for raising concerns.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. There were some periods during the day when people and relatives felt that there were insufficient staff in some areas of the home.

The environment was clean and well maintained and this helped ensure that people were protected from and potential infections.

When we spoke with staff they knew how to recognise and respond to abuse correctly. Staff responded in the right way when people's behaviour was challenging.

Is the service effective?

Good

The service was effective.

Arrangements were in place to ensure that people had access to healthcare services and receive ongoing support if required.

Staff had an induction when they started in their roles and up-to-date training.

People enjoyed the care home's food and had a choice about what and where to eat. Plans were in place to ensure that people's nutritional needs were met.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's privacy and dignity was usually respected. We saw one occasion during our inspection when we felt a person's dignity was not respected. People were positive about the care they received. and we saw they were involved in decisions about their care on a day to day basis.

Following our inspection we spoke with a visiting health professional who told us that the service was very caring.

People's end of life care was recorded and staff followed the agreed plan however we found that the do not attempt cardiopulmonary resuscitation forms, (DNACPR's) which we reviewed were not completed fully.

Is the service responsive?

Requires Improvement

The service is consistently responsive.

People told us that they were able to make everyday choices and during our visit we observed this happening.

Activities were available throughout the day and we observed people being supported to participate in these.

The provider had a process in place to ensure that staff were kept up to date so that they could meet people's changing needs.

Summary of findings

Is the service well-led?

The service was not consistently well led.

Relatives and people who lived at the home told us that they felt able to raise concerns but they were unclear about the process for raising concerns.

The provider had a process in place for recognising staff achievements and three members of staff from the home had recently been awarded this.

The systems that the manager had put in place for monitoring quality were not consistently effective we found that they had not picked up the concerns raised by ourselves.

Requires Improvement

Woodgrange

Detailed findings

Background to this inspection

We visited the home on 9 July 2014 and spoke with four people living at Woodgrange, four relatives, four nurses, one care staff, the registered manager and the chef. We observed care and support in communal areas and also looked at the kitchen and some people's bedrooms, as well as a range of records about people's care and how the home was managed. We looked at five people's care records in detail

The inspection team consisted of a lead inspector, one other 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 service

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed five people for one hour. During this period we observed positive interactions for most of the period of time.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the home and contacted the commissioners of the service to obtain their views. Following our inspection we spoke with a visiting professional about their experiences of care within the home.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe.

Through our observations and discussions with people, we found that there were occasions when there were insufficient staff with the right experience or training to meet the needs of people. For example at 12 noon there was only one member of staff remaining within the lounge/ dining area and they were busy setting the tables for lunch. During this period one person was trying to get out of their chair and required assistance. A senior member of staff who was passing through the unit noticed this and supported them to sit down. They also reminded them that they would fall over if they stood up. The senior member of staff asked the staff member who was setting the tables to watch this person. However, the person continued to try to get up and was observed to be at risk of falling.

We also observed staff were involved in preparing for lunch and there were incidences when people were left without care. For example one person had finished their cup of coffee and continued to try to drink from an empty cup. Unfortunately staff did not notice this and the person was not offered another drink.

At the same time another person had become distressed and although the senior member of staff reassured the person briefly, they continued to be distressed for the next twenty minutes, during which time no one else attended to them.

We spoke with people living in the home and relatives about staff numbers and they told us there were occasions when they thought there was insufficient staff. For example one relative told us about the Memory Lane unit, “There are odd times when staff numbers are insufficient. Late morning seems a period when they are hard pushed to get to patients sufficiently quickly.” This was supported by our observations.

Another relative said, “There are insufficient staff in the downstairs lounge. There is one carer there and when bells are ringing in rooms the pressure is on. When she gets called away there’s no one there. If my relative wants the toilet she’s got a problem because there isn’t a bell nearby and there’s no carer to help her. They need a second carer in there.”

When we spoke with staff they told us that there were some times during the day when they were very busy and sometimes people may have to wait for a response. One member of staff we spoke with told us that they thought there were on occasions insufficient staff in the downstairs area to provide timely care. All the staff we spoke with told us that they worked together as a team across the home and supported each other. The senior nurses told us that they preferred to provide cover from the staff team rather than use agency staff because this meant people were cared for by staff who knew their needs.

We spoke with a member of care staff who was able to tell us how they would respond to allegations or incidents of abuse, and also knew the lines of reporting in the organisation. We saw that guidance was available to staff. In addition, we had evidence that the registered manager had notified the local authority, and us, of safeguarding incidents. All the people we spoke to who lived at the home said that they felt safe. The four relatives we spoke to also said that they were not concerned about their family member’s safety at the home. One person said, “The support from staff ensures my (family member)is safe in this environment.”

We saw that staff were skilled in responding to behaviour that challenges. The situations we observed were managed well by the staff. We observed staff followed the guidance in individual care plans about how to support people when they were confused and upset. For example, when a person became aggravated a member of staff went over to them, put their arm around them and spoke quietly to calm the situation.

Where people did not have the capacity to consent, the provider acted in accordance with

the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). The provisions of the MCA are used to protect people who might not be able to make informed decisions on their own about the care or treatment they received. Where it is judged that a person lacks capacity then it requires that a person making a decision on their behalf does so in their best interests. We saw in the care records mental capacity assessments had been completed and details included as to what areas of care these related to, for example personal care.

Requires Improvement

Is the service safe?

At the time of our inspection there was one person who was subject to DoLS. This had been applied for and approved and was under review to ensure it remained a valid DoLS.

During our inspection we looked around all areas of the home and found that the home and equipment was clean and well maintained. For example, we saw that people's bedrooms and communal bathrooms, were properly cleaned and records maintained regarding the frequency of cleaning. We saw that communal areas were well decorated and chairs and tables were clean.

We saw that the provider had a process in place for the safe recruitment of staff which included carrying out checks and obtaining referances. The staff we spoke with told us that before they started employment with the provider they had been subject to this process.

Good

Is the service effective?

Our findings

Three of the relatives we spoke with told us that they knew about their family member's care plan and had been involved in reviewing or the setting up of the plan. People told us that they knew that staff kept records about them, such as what they ate and drank but only one person we spoke with was able to tell us about their care plan.

Throughout the inspection we saw people had access to drinks and additionally staff checked that people had drinks and offered drinks on a regular basis. There were also kitchen areas available for people to obtain their own drinks and snacks if required.

Staff ensured that people were eating enough to keep them healthy. We saw that three people had been assessed as being nutritionally at risk and staff had made the appropriate referrals and developed a care plan to support this person.

We saw that two of the people whose records we looked at needed to have their fluid intake monitored and staff recorded what they drank each day. When we looked at the records we found it was not clear how often people should be offered drinks.There were gaps of up to eight hours in the record where no fluids were recorded as given. This meant staff were unable to use the records to monitor people's fluid intake and ensure that they received adequate fluids. However during our visit we observed people being offered drinks on a regular basis by staff and saw that people had opportunity to access drinks when they required.

When we observed lunch we saw that people had specialist equipment to support them to eat independently for example, plate guards and cups with straws. Lunchtime in all three dining areas was calm and we saw staff interacting positively with people whilst supporting them with their meal. People were asked what they wanted and offered alternatives if they were unhappy with the choice.

Care records included information about people's nutritional needs including risks such as choking and malnutrition. We spoke with the chef who was able to tell us about people's individual needs. They told us that they were involved in staff meetings and also resident and relative's meeting to ensure that they were kept up to date with changes and were meeting people's needs and choices.

Care plans included information about what name people preferred to be known by and we saw that staff used these names. The plans also included risk assessments for pressure care, falls, mobility and nutrition. Records showed that people had regular access to healthcare professionals, such as GPs, physiotherapists, chiropodists, opticians and dentists. Where people had specific health needs such as epilepsy there were care plans in place to guide staff about how to support these people. We spoke with staff and they were able to tell us about these issues and how they would support people. This meant that the provider responded in an effective way to ensure people's health care needs were reliably met.

People had been referred to other professionals regarding their health needs. In particular, we saw in three of the records we looked at evidence of involvement from the dietician. The dietician had provided guidance for staff and we saw this had been followed.

We spoke with three nurses one of whom was responsible for training. They confirmed that all staff had an induction when they started work at the home. Other staff told us that they had support when they needed it and confirmed that they had received additional training on issues such as safeguarding, dementia care and fire safety. They also said that they had received appraisals and felt the senior team were supportive. We looked at records of training and saw there were plans for training for the forthcoming year. We saw that there was an appraisal plan in place for 2014. Staff said that they were confident about challenging and reporting poor practice, which they felt would be taken seriously and acted upon.

Staff told us, and records confirmed that they had recently received training in dementia care to ensure that they were able to meet people's needs. They said that before staff were able to work on the Memory Lane. Unit they had to have completed the dementia care training.

We spoke with three members of staff and they all told us that they felt staff worked as a team and supported each other. All the staff we spoke with told us that they felt able to discuss concerns and issues with nurses and team leaders.

Requires Improvement

Is the service caring?

Our findings

We received positive comments from all the relatives and people we spoke with about staff and the care that people received. For example one person said, "I am happy with my relative's care, staff are wonderful and go the extra mile for my relative" Another person told us, "The staff are really keyed in to my relative's needs."

We saw staff and people who lived in the home interacting well. For example, when staff supported a person to move from a wheelchair to a chair they explained what they were doing and what the person needed to do to assist them. In the upstairs unit we observed staff supporting people to participate in activities such as a quiz and discussing the recent news.

We carried out a SOFI for an hour in the Memory Lane unit and observed five people. During this period we found that interactions were positive. People were calm and happy in their surroundings.

People said that staff respected their privacy and dignity. We saw that staff knocked on people's bedroom doors before entering and called people by their preferred name. However, on one occasion we observed two members of staff talking about another person when they were assisting a person to move.

The care plans we looked at included information about people's preferences, such as how they communicated and their personal history. For example one person who spent most of the day in bed preferred to wear a tee shirt during the day. This was detailed in the care plan and when we spoke with a member of staff about this person's care they were able to tell us about their preferences'. We visited the person and saw that their preferences had been observed.

After our inspection we spoke with a visiting healthcare professional about the care people received. They told us that staff were always aware of people's needs when they visited. They said, "Staff are always very caring and kind." And, "They [staff] are aware of how to care for people."

Care plans set out people's preferences for when they reached the end of their life. The care plan for a person nearing the end of their life described the end of life care they wanted to receive so that staff could support themwith their choices of care.

All the people whose records we looked at had 'do not attempt cardio pulmonary resuscitation' (DNACPR) in place .These are used when it is considered not in the person's best interest to carry out resuscitation.

However, when we looked at these we found only one out of the five DNACPR's was completed correctly. One of the orders was a photocopy which would not be accepted by the ambulance service if required. In the other three we found that they had been authorised by a relative, however, the sections about a person's capacity had not been completed. This meant it was unclear why relatives had signed on people's behalf and people may receive resuscitation inappropriately. The DNACPR's were not completed by the staff who worked at the home however staff should be aware of the implications of incorrectly completed forms as they would be seen as invalid by the ambulance service. The registered manager told us that they would discuss this with the GPs.

Requires Improvement

Is the service responsive?

Our findings

The people we spoke with told us that they had their choices respected. During our visit we observed occasions when people were given choices by staff about their care for example what food they would like and if they would like to join in activities.

One person received additional support from staff for most of the day so that they could access activities and participate in their care. We observed that the staff who was supporting them engaged with them and the person was involved in meaningful activity. Throughout our inspection we observed that activities were available to people. During our inspection the hairdresser was visiting and people also told us that they enjoyed having their nails manicured.

We spoke with the activities coordinator and they told us about a system they operated at lunchtime to ensure that care staff were able to respond to people's needs. The system meant that the activities coordinator was available to fetch additional meals or items required during mealtimes rather than the care staff leaving the dining area.

We saw that information booklets were available to people which informed them about the care they could receive and how to contribute to their care plans.

Staff were able to tell us about consent and we observed that staff asked people if they required assistance before they provided it. For example, we saw staff asked people where they would like to sit and if they wanted to take part in activities such as looking at a photograph album. Where people refused care on a regular basis risk assessments were in place and guidance about what actions staff should take was included in the record. When we spoke with a member of staff about this they were able to tell us what actions they would take.

When we looked at the care records we found two separate examples where records had not been completed fully. It was not clear from the records what care had been provided. For example topical cream records did not state when people required cream applying and fluid charts had gaps in them. Body maps were used to show staff where to apply topical creams to ensure they were applied in the correct area.

We asked people and their relatives if they were aware of their care plans. All of the relatives we spoke with told us that they were aware of the care plans and one person told us that they contributed to it. Three of the people we spoke with who lived at the home were unable to tell us about their care plans. We saw in the care plans we looked at that care plans had not been signed consistently by the person or their representative to say that they were happy with their care plans. It was not clear from the records whether or not people had been consulted and if they were able to sign their care plans to say that they were in agreement with the proposed care. People were at risk of receiving care they had not agreed to.

The registered manager told us that they held a daily handover meeting to ensure that staff were kept up to date with people's changing needs. When we spoke with a carer they told us that they had recently returned from being on days off and had received both an update from the senior care staff and also a handover as part of the regular updates.

The home is part of the Barchester group and had recently been recognised as an exemplar site for dementia care within the group. This meant that it would be used to show other homes how to care for people with dementia. The registered manager told us that all the staff had participated in introductory training about dementia and that care and nursing staff had gone on to do further more detailed training. The staff we spoke with told us that they felt more confident in supporting people with dementia following the training.

There had not recently been a satisfaction survey carried out with people and their relatives. However, when we spoke with them they told us that they felt comfortable in approaching nursing staff if they had concerns or complaints.

A meeting with relatives and people who lived at the home had been held in May 2014. Issues had been raised about meals and car parking. They said that copies of the minutes were made available to people and their relatives so that they were kept informed of issues and actions.

Requires Improvement

Is the service well-led?

Our findings

A relative told us, “I’ve met the manager only once I don’t see her around the building.” One person said, “I go to the nurses if I have a problem,” and another said, “I don’t know the manager very well.” Only one of the relatives we spoke with told us that they would speak with the registered manager if there was a problem. The other relatives told us that they would speak with the nursing staff. People and relatives were not consistently clear about the structures for reporting and raising concerns. This meant there was a risk that issues that required the support and involvement of the management may not have been raised appropriately.

Arrangements had been put in place to ensure that there was sufficient senior support for staff. During weekdays both the registered manager and deputy manager were supernumerary and they were supported by two heads of unit who were qualified nurses. They told us that this allowed them to spend time on monitoring care and quality issues.

At the time of our inspection the home had two vacancies for qualified nursing staff. The carer we spoke with told us that the staff worked as a close team and supported each other. They told us that whenever possible staff were flexible so that sufficient cover was provided. For example, staff would work longer or come in earlier rather than use agency staff if they were short. This arrangement provided continuity of care for people.

The provider had established staff excellence awards and three of the staff at the home had been awarded these recently in recognition of their expertise and commitment.

A system for quality assurance monitoring was in place which included visits by the provider and a yearly quality review. We saw that action plans were in place to address any actions identified by the audits. When we spoke with staff they told us that they received feedback from quality monitoring and were involved in subsequent changes. This helped ensure that the quality of care provided to people was maintained to a high standard.

Audits were carried out on areas such as infection control, medicines and care plans. We found that these had not picked up some of the issues that we found during our inspection. For example we found incomplete fluid charts that had not been picked up by the service’s own audit systems which meant that the provider did not have systems in place to assure themselves that people were being protected from the risk of dehydration. Gaps in care records regarding consent should also have been picked up as part of the audits so that the provider could be assured that staff understood that care should be provided with people’s consent.

We saw there were plans in place for emergency situations, such as an outbreak of fire. Staff understood their role in relation to these plans and had been trained to deal with them.