Miss Satwant Chahal

Woodthorne Care Home

Inspection report

12 Thompson Street
The Manor
Willenhall
West Midlands
WV13 1SY

Tel: 01902606365

Date of inspection visit:
04 January 2017
05 January 2017

Date of publication:
14 March 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 4 and 5 January 2017.

Woodthorne Care Home provides accommodation and personal care for up to 21 older people and also provides a service for people living with dementia. On the day of our inspection there were 17 people living there.

At our last inspection on 4 November 2015, the provider was in breach of regulations 18 relating to staffing levels, 11 need for consent and 17 that relates to good governance.

The provider sent us an action plan that showed measures would be taken to comply with the regulations. At this inspection we saw that improvements had been made. However, there were areas that needed to be reviewed and improved to ensure people received a safe service.

The home had a registered manager who was also the registered provider. The registered manager was present on the second day of the inspection to receive feedback about the inspection. The deputy manager was in charge of the home in the absence of the registered manager. In the report we make reference to the deputy manager as 'the person in charge.' 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Improvements had been made to ensure enough staff were on duty to meet people's care and support needs. People were not appropriately supported to take their prescribed medicines and this placed their health at risk. People could not be confident that recruitment practices would ensure the suitability of staff who worked with them. People were not protected from the risk of further accidents because the provider had not taken action to avoid them happening again. People told us they felt safe living in the home and staff were aware of their responsibility to protect them from potential abuse.

People were supported by skilled staff who received one to one [supervision] sessions. People told us that staff always obtained their consent before providing them with care and support. People were assisted by staff to access relevant healthcare services when needed. People were provided with a choice of meals and had access to drinks at all times.

The provider's governance remained ineffective and did not ensure people always received a good service. Systems were in place to encourage people to have a say in how the home was run. Staff felt supported by the managers to carry out their role.

People were involved in their care assessment. However, their interests and hobbies had not been explored by staff and people were not always provided with support to do things that interested them. People felt

comfortable to share their concerns with staff and could be confident concerns would be listened to and acted on.

People received care and support from staff who were kind and compassionate. People's involvement in planning their care ensured they received support the way they liked and their privacy and dignity was respected.

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

The service was not safe.

People were at continued risk of accidents because the provider had not taken action to avoid this happening again. The provider's recruitment practices did not ensure staff were suitable to work in the home and this placed people at risk. People could not be confident they would be supported to take their prescribed medicines safely.

Is the service effective?

Good

The service was effective.

People were cared for and supported by skilled staff who received one to one [supervision] sessions. People's consent was obtained by staff before care and support was provided and they were assisted to access relevant healthcare services. People were provided with suitable meals and had access to drinks at all times.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind and compassionate and who promoted their rights to privacy and dignity. People were involved in their care planning to ensure they received care and support that reflected their preference.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were involved in their care assessment but staff did not explore their interests or hobbies. People felt confident to share their concerns with staff and could be confident their concerns would be listened to and acted on.

Is the service well-led?

Requires Improvement

The service was not well-led.

People could not be confident they would receive a safe service because the provider's governance was ineffective. People were encouraged to have a say in the running of the home and staff felt supported by the managers.

Woodthorne Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 4 and 5 January 2017 and was unannounced. The inspection team comprised of one inspector.

As part of our inspection we spoke with the local authority to share information they held about the home. We also looked at information we held about the provider to see if we had received any concerns or compliments about the home. We reviewed information of statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We used this information to help us plan our inspection of the home.

During the inspection we spoke with five people who used the service, two relatives, three care staff, the cook, the deputy and the registered manager. We looked at two care plans and risk assessments, medication administration records, accident reports, two staff files and quality audits.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 4 November 2015, the provider was in breach of regulation 18, of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We found there were insufficient staffing levels to meet people's needs. The provider sent us an action plan that showed measures would be taken to increase staffing levels.

At this inspection we found that the provider had taken action to comply with the regulation. People told us staff were always available to assist them when needed. One person said, "Staff are always available to help me." A different person informed us, "Staff are always around when you need them." We spoke with a visitor who said, "There is always enough staff on duty and nothing is too much for them." We saw staff were available to support people when needed.

The person in charge confirmed staffing levels had been increased during the day to ensure people's needs were met. They said three care staff were provided throughout the day and they were confident that staffing levels were sufficient to meet people's needs. They said staffing levels during the day time were determined by people's dependency needs. However, staffing levels during the night time had not been reviewed. The person in charge told us that two staff were provided during the night time. Two people who used the service required two staff to meet their personal care needs. This meant when staff supported these people, there were no other staff available to assist others if and when needed. However, the people we spoke with did not raise any concerns about staffing levels during the night time. The person in charge assured us that staffing levels for the night time would be reviewed to ensure people were appropriately supported.

At our previous inspection we found that the provider's recruitment practices were unsafe. Appropriate safety checks had not been carried out to ensure staff were suitable to work in the home. At this inspection we looked at two files for staff who had recently commenced employment at the home. We found that the provider had not taken action to ensure the appropriate safety checks were carried out. This meant people remained at risk of being cared for and supported by unsuitable staff. However, the staff we spoke with confirmed they had a Disclosure Barring Service [DBS] check and a request was made for references before they started to work at the home. The DBS helps the provider make safer recruitment decisions to ensure the suitability of people to work in the home.

People were not appropriately supported to reduce the risk of accidents. At our previous inspection we found that accidents were not always recorded. At this inspection we saw a record was maintained of accidents. However, the provider was unable to show what action had been taken to avoid a reoccurrence. Discussions with the person in charge acknowledged that appropriate measures had not been taken to reduce the risk of further accidents. This meant people remained at risk of harm.

People were not appropriately supported to take their prescribed medicines. At our previous inspection people's prescribed medicines were not managed safely. At this inspection we found the provider had not taken sufficient action to ensure people were supported to take their medicines. For example, there were no safety systems in place to ensure people who self administered their medicines took them as directed by the

prescriber.

People who were reliant on staff to manage their medicines said they received them when needed. We saw that medication administration records were signed by staff to show when medicines had been given to people. These medicines were stored appropriately and a record of medicines returned to the pharmacist was maintained. People had been prescribed medicines to be given 'when required.' These are medicines that are only given when needed. For example, for the treatment of pain. Discussions with staff confirmed they were aware of how to manage these medicines.

People told us they felt safe living in the home. One person said, "I feel safe here because the staff support me so well." We spoke with their visitor who said, "I feel assured that [relative] is safe here and I can now sleep at night." Another person told us, "I feel safe because staff are good to me." We spoke with different visitor who said, "[Relative] is safe here because staff are always nearby and they keep an eye on them."

People were protect from the risk of potential abuse because staff knew how to protect them. All the staff we spoke with were aware different forms of abuse and their responsibility of sharing any concerns of abuse with the registered manager. Staff were also aware of external agencies they could share their concerns with. Discussions with the person in charge confirmed their understanding of when to share information about abuse with the local authority to protect the person from the risk of further harm.

Good

Is the service effective?

Our findings

At our last inspection on 4 November 2015, the provider was in breach of regulation 11, of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We found that people's consent for care and treatment was not always obtained. Staff had limited understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People's liberty had been unlawfully deprived. At this inspection we found that the provider had taken sufficient action to comply with this regulation.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The people we spoke with confirmed staff always asked for their consent before they provided care and support. One person said, "The staff always ask if I want my medicines." One staff member said, "Regardless to whether the person is living with dementia I always obtain their consent and provide them with a choice. We found that not all the staff we spoke with were aware of MCA. However, the people we spoke with did not share any concerns about staff not obtaining their consent. The person in charge informed us that arrangements had been made to provide further MCA training to give staff a better understanding about how to include the principles in their work practice.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The person in charge said four DoLS applications had been submitted to the local authority to deprive people of their liberty. They told us these people were living with dementia and lacked capacity to make a decision. They told us it would not be in their best interest to allow them to leave the home without the support from staff as this would place them at risk of harm. They confirmed a mental capacity assessment had been carried out to determine whether these people had capacity to make a decision, to ensure the DoLS application was appropriate.

People were supported by staff who received regular training. One person told us, "The staff are brilliant, they know what they are doing." We spoke with a visitor who said, "The staff appear skilled, they seem to know what they are doing." Staff told us that access to training gave them the skills and knowledge to carry out their role properly. Discussions with staff and the person in charge confirmed observations of work practices were carried out by the registered manager. This was to ensure skills learnt by staff were put into practice so people received the appropriate care and support. Staff confirmed they had access to one to one [supervision] sessions. A staff member said, "During my supervision discussions are held about my work performance and where improvements could be made." Staff told us supervision sessions provided them with the support to carry out their role.

People told us they were provided with a choice of meals. One person said, "We have three meals a day and

we have a choice." They told us they had access to snacks and drinks at all times. We saw that people were regularly offered drinks. One person said, "We can have a drink when we like, you just have to ask." Staff were aware of suitable meals for the individual with regards to their likes, dislikes and health condition. A staff member said if they had concerns about how much a person ate and drank this would be recorded and monitored. They said concerns would be shared with the person's GP, dietician or a speech and language therapist. These healthcare professionals would provide the person and staff with advice about suitable meals. We saw staff were available to support people with their meals when needed. The cook entered the dining room and asked people if the meal was alright. One person did not like their meal and the cook offered them an alternative. A menu board was located in the dining room that provided information about meals on offer and we saw these meals were provided as identified on the menu board.

People confirmed they had access to healthcare services when needed. One person said, "The staff will call the GP if I am unwell." They told us, "I saw the optician a few months ago and had some new glasses." We spoke with a visitor who informed us that staff supported their relative to attend their medical appointments. Discussions with another visitor confirmed, "The staff are very quick to obtain medical intervention when needed." A staff member said a person had sustained a fall and immediate medical intervention was obtained by requesting an ambulance. Staff told us people who had specific health conditions. For example, diabetes, they had access to a specialist nurse to monitor their health condition. During the inspection we heard a staff member share concerns with a GP regarding a person's health and obtained advice about the appropriate action to take to support the person.

Good

Is the service caring?

Our findings

At our previous inspection we found that people's right to privacy and dignity was not always respected by staff. At this inspection people told us staff always valued their privacy and dignity. One person told us the staff supported them with their personal care needs and said, "They do respect my privacy." Staff had a good understanding about the importance of respecting people's right to privacy and dignity. One staff member said, "I always knock on people's door before I enter their bedroom." Another staff member told us about a person living with dementia who did not always dress appropriately to maintain their dignity. The staff member said they always helped them and suggested different ways of dressing to ensure their dignity and we saw this.

People were treated with kindness and compassion. One person said, "The staff are very nice and they do help me." Another person told us, "The staff are always around and they are pretty patient with me." We spoke with a different person who said, "I don't tend to ask staff for help but if they see me struggling they will help me." We spoke with a visitor who said they had no concerns about the care provided to their relative. We observed when staff entered the lounge they took the time to acknowledge people and talked with them to find out if they were alright. We saw one person was very agitated and did not want to sit at the table to eat their meal. The staff member was very calm and patient with the person and walked around the room with them offering them another place to sit. The person appeared more comfortable and settled to eat their meal in a quieter area away from others. The staff member stayed with the person and reassured them.

People were unable to remember if they were involved in making decisions about their care and support. However, staff confirmed they were. One person told us that no one asked them how they would like to be cared for but they were happy with the care and support they received. We spoke with a different person who confirmed staff always asked how they would like to be cared for and where they needed help." A staff member said, "I always ask people how they would like to be supported." This ensured people received care and support the way they liked.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 4 November 2015, people told us there were some leisure opportunities available but felt more could be done in this area. At this inspection we received mix comments about the availability of social activities within and outside the home. One person said, "There are no activities available, I watch the television and walk around the grounds, there is nothing else to do." Another person said, "I sometimes get bored but I'm not sure what I would like to do." We spoke with a visitor who said, "I've never seen any activities take place, they just sit in the chair." Three people told us it was their choice not to go out. One person said, "I don't want to go out I'm quite happy sitting here." A different person said, "Although I like going for walks I'm quite happy sat here reading." A staff member said, "We should have more activities available for people. However, some people don't show an interest." The staff we spoke with were unaware if people's interests and hobbies had been explored to engage them in things that interested them. We arrived at the home at 9am, at 11am we shared concerns about the lack of stimulation provided to people. A staff member immediately played music which was loud, so people were provided with a mixture of music and television which were on at the same time. People did not seem to appreciate this and we saw one person leave the room. Another person who was living with dementia appeared agitated and said they wanted to go home.

Staff informed us that people were provided with card games, bingo and sing along. We were informed that in warmer months people were supported to go for walks at the local park and to go shopping and this was confirmed by one person. One person told us their family often took them out and said, "If I ask the staff they would take me out." People told us they had recently visited the local museum and enjoyed the day out. They informed us about the 'pub night' where they had access to a bar in the home. One person said, "The other day staff took me out for a lovely walk."

The provider offered a service to people from different ethnic groups. Staff were aware of people's cultural needs in relation to their personal care needs, food preference and religion. People were supported by staff to maintain their religious beliefs and religious services took place within the home. The person in charge said people would be supported to visit their chosen place of worship if they wished.

People were encouraged to be involved in their care assessment to ensure they received a service that reflected their preference. We spoke with a visitor who told us their relative was living with dementia. They told us their relative was involved in their assessment and the records we looked at evidenced this. We spoke with this person who confirmed they were happy with the care and support they received. Discussions with people who used the service and staff confirmed the care provided was 'person centred.' However, this was not reflected in the support provided to ensure people lived a lifestyle of their choice in relation to their interests and hobbies.

All the people we spoke with said they had never made a complaint. They told us if they had any concerns they would share this with the staff. They were confident that staff would listen to them and address their concerns. We saw complaints were recorded and also showed what action had been taken to address them. This showed complaints were listened to and acted on.

Requires Improvement

Is the service well-led?

Our findings

At our last two inspections in July 2014 and November 2015, the provider was in breach of regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. At this inspection we found that the provider had taken some action to improve their governance to drive improvements. However, there were still areas that needed to be reviewed and developed to ensure people received a safe service. For example, the management of medicines was not entirely robust to support people who wish to manage their medicines. For example, a staff member who was responsible for the management of medicines said three people managed their medicines. Further discussions with this staff member confirmed there were no systems in place to ensure these people took their medicines as prescribed. The person in charge confirmed that people who managed their medicines did not have a secure area to store them. This meant other people may have access to medicines that had not been prescribed for them and this placed them at risk of harm. On the second day of our inspection the person in charge had taken appropriate action to address these concerns.

Staff had access to written information about how one medicine should be stored and administered. However, discussions with the staff member who was responsible for the management of medicines and the person in charge confirmed they had not followed this guidance. This placed the person's health at risk. On the second day of the inspection the person in charge had contacted the GP for advice and took appropriate action to ensure the person was supported to take their medicine safely.

At our previous inspection the provider's recruitment practices were not entirely safe to ensure staff were suitable to work in the home. At this inspection we looked at two files for staff who had recently started to work at the home. We found one file did not contain evidence of safety checks being carried out. The person in charge confirmed this had not been carried out but was unable to explain why. The person in charge confirmed this staff member worked unsupervised and a risk assessment had not been carried out to ensure people's safety. The person in charge assured us that a DBS application had recently been submitted for this staff member.

People remained at risk of accidents and injury because the provider had not taken action to reduce the risk of it happening again. For example, records showed there had been 35 falls by various people within six months. One person was living with dementia and required the use of a walking equipment. Accident records showed they had sustained nine falls within six months. The person in charge acknowledged they had not considered a referral to the falls clinic. The person had not been reassessed to ensure their walking equipment was still suitable for them. This meant the person remained at risk of further falls.

We found that another person had sustained six falls within six months. The person in charge was unable to demonstrate what action had been taken to reduce the risk of further falls and the person remained at risk of harm. These people had a risk assessment in place that provided staff with information relating to their mobility and risks of falls. Both people were identified as high risk of falls. However, the risk assessments did not provide staff with sufficient information about how to reduce this.

The provider had not taken sufficient action to ensure their governance drove the necessary improvements to make sure people received a safe service.

This is a breach of Regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The person in charge informed us that since our last inspection quality assurance audits had been implemented to review the quality of service provided. For example, the handover of shifts had been reviewed to ensure staff had sufficient information relating to people's care and support needs. This enabled staff to provide consistent care.

'Resident of the day' had been developed. This focused on the person's needs and gave the person the opportunity to express their views in relation to the service provided. 'Dining experience' had been implemented to gather people's views about the meals provided. For example, one person told us the meal portions were small and they said they were sometimes hungry. The cook was aware of this because this had been identified during the review of people's dining experience and we saw this had been recorded. The cook said the person was now provided with larger meal portions. An audit of mattresses identified they were no longer suitable and people were provided with a new one to ensure their comfort and safety.

People had a say in how the home was run. Meetings held with people gave them an opportunity to tell the provider about their experience of using the service. Records showed discussions in these meetings related to menu planning, forthcoming social activities and changes to the staff team. The person in charge said during these meetings people's views were listened to and acted on. For example, people were involved in discussions about redecorating the home and were given the opportunity to choose the colour scheme.

The person in charge said routine staff meetings were carried out and staff confirmed this. One staff member said the registered manager listened to their views. For example, they had raised concerns about operational practices within the home which had a negative impact on people. They informed us that the registered manager took immediate action to address this to improve the service provided. Another staff member said they had made suggestions about making care plans more 'person centred' so staff had access to relevant information about people's care and support needs. They told us this had been done and we saw this.

The home was run by the registered manager and the deputy manager. Although people who used the service were unaware of who was running the home they told us they were comfortable with approaching all the staff. A staff member said the managers were approachable and supportive. Another staff member said, "The managers are approachable and listens to your ideas and takes them on board." The registered manager told us they undertook routine training to maintain their skills.

The person who was in charge in the absence of the registered manager told us they had aspiration to obtain further dignity training for staff in view of having a dignity champion in the home. This would ensure all aspects of the service provided to people would promote their right to dignity.

Discussions with the person in charge confirmed they were aware of when to send us a statutory notification which they are required to do by law.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not taken sufficient action since the last inspection to ensure their governance drove improvements to ensure people received a safe service.