Care Quality Commission

Miss Satwant Chahal

Woodthorne Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 3 and 4 November 2015 and was unannounced. At the last inspection on 25 July 2014, we asked the provider to take action to make improvements regarding the management of medicines and also assessing and monitoring the quality of the service provided to people, and this action has not been fully completed. At our inspection completed in November we found that further improvements were still required.

Woodthorne Care Home is a residential home that provides accommodation for up to 21 people who require personal care. At the time of the inspection there were 20 people living at the service. Most of the people who lived at the service are older people living with dementia. The service is required to have a registered manager in post and there was a registered manager at the time of the inspection. 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.

Summary of findings

People told us that there were not sufficient numbers of care staff available to meet their needs. We saw that people did not always receive support when they needed it. People were not always protected from harm through recruitment practices that ensured appropriate staff were employed.

People told us that they were happy with how they received their medicines. We found that medicines administration and storage was not always safe. People were not always protected by robust infection control practices.

Risk assessments were in place but were not always updated or consistent in accurately reflecting people's needs. Accidents and incidents were not consistently recorded.

People told us that they felt safe living at the service. Staff could recognise signs of abuse however they were not confident in whistle blowing procedures. People's health and human rights were not always protected through the effective use of the Mental Capacity Act 2005.

Most people told us that staff had the right skills to support them effectively. People told us that they were happy with the food and drink that they received. People's day to day healthcare needs were met.

People's dignity was not always protected by staff. Most people's independence was promoted with the use of mobility aids. People told us that they were able to make choices around the care they received. People told us that they felt staff were caring. People were supported to maintain relationships that were important to them.

People told us that there were leisure opportunities available to them but they felt more was needed. People told us that they were not fully involved in developing their care plans. People who had religious beliefs were supported to continue practising their religion.

People told us that they knew how to make a complaint if required. Complaints and feedback had not been recorded although people told us that their concerns had been responded to.

The provider did not have robust systems in place for identifying and managing risks to people and monitoring and improving the quality of service provided to people. People told us that they felt the service was well managed but they weren't always sure of who the manager was.

Staff told us that the culture within the service was open and that they felt supported and involved by management.

We found that the provider was in breach of some regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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?
The service was not always safe.

People did not always receive support when they needed it due to the availability of staff at certain times of the day. People told us that they were happy with how they received their medicines although storage and administration practices were not always safe. Risk management was not always robust.

People told us that they felt safe living at the service. Staff could recognise the signs of abuse but were not certain how to whistle blow if this was required.

Requires improvement

Is the service effective?
The service was not always effective.

People's human rights were not always protected through effective use of the Mental Capacity Act 2005.

People told us that staff had the right skills to support them effectively. People enjoyed the food and drink that they received. People's day to day health needs were met effectively.

Requires improvement

Is the service caring?
The service was not always caring.

People's dignity was not always protected effectively by staff.

People told us that they were able to make choices about their care. People were supported to maintain relationships that were important to them.

Requires improvement

Is the service responsive?
The service was not always responsive.

People were not always supported to access a range of leisure opportunities. People told us that they were not always fully involved in planning their care.

People told us that they knew how to complain if required. People felt listened to and that their concerns were responded to.

Requires improvement

Is the service well-led?
The service is not always well-led.

People were not protected by sufficient systems that identified and managed the risks to them. People's experience living in the service was not effectively monitored.

Requires improvement

Summary of findings

People were supported by a staff team that told us they felt supported and motivated in their roles. People told us that they weren't always certain who the manager was.

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 3 and 4 November 2015 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we reviewed the information we held about the service. We looked at statutory notifications sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We obtained information and views from the local authority about the service. We used this information to help us plan our inspection.

The registered manager was on duty on the day of the inspection. We spoke to the registered manager following the inspection. During the inspection we spoke with nine people who lived at the service. Some people who lived at the service were unable to share their experiences so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the deputy manager, three members of care staff, one visiting health care professional and six visitors who were relatives of people living at the service. We reviewed records relating to medicines, three people's care, three staff files and records relating to the management of the service including audits and complaints records. We also carried out observations across the service regarding the quality of care people received.

Requires improvement

Is the service safe?

Our findings

At the inspection completed in July 2014 we found the provider was not meeting the regulation regarding management of medicines. At the inspection completed in November 2015 we found that the provider was meeting the requirements of the law but further improvement was required.

People told us that they didn't feel that staff were always available when they wanted support from them. One person told us, "I find that the staff are always too busy to speak to me". Another person said "I sometimes have to wait a while for the staff to take me to the toilet". A third person said, "I have a buzzer and most times they take a while to come when I press it." Relatives of people also told us that they felt more staff were needed. One relative said "Sometimes I think that they could do with more staff."

We saw that there were frequent periods during which staff were not able to meet people's needs. On the first day of our inspection a person was seen struggling to walk safely across the lounge and there were no members of staff present. The lounge and dining area is one large communal room where people spend most of their day. We located a member of staff to provide support to the person. Staff members told us that this person was known for having issues with their mobility. Shortly after this event, the same person required further support to mobilise in the lounge. To provide support to this person, a member of staff had to stop providing one to one support required by another person as they were the only staff member available. On the second day of our inspection we saw two people shouting for their breakfast while another person was attempting to get out of their chair with their walking frame and stumbling backwards. One person approached an inspector in the lounge and asked them for their breakfast. We located a staff member to alert them to the fact that people needed support. People told us that they sometimes had to wait at mealtimes. One person told us "The thing about lunch time is that they get us to the table and do not bring the lunch until an hour later. By then I want to go to the toilet again."

During the morning medicines round on the second day of the inspection, we saw the senior carer responsible was required to stop administering medicines to provide additional support to people when no other staff members were present. The deputy manager had advised that two members of staff normally work together to ensure the safe administration of medicines. The senior carer was observed completing the medicines round alone. We were told by staff that this was due to an extra staff member not being available. The registered manager confirmed that there was currently no formalised method of assessing staffing levels. They advised us that they were developing a tool in order to help them assess and review the staffing levels.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

People told us that they were happy with how they received their medicines. One person told us "When the staff give my medication, they make sure that I take it. They bring them regularly and on time." Another person also told us that they always received their medicines on time. We saw that two prescribed creams were being stored on a radiator in one person's room. A senior carer assured us that this was an error and that creams were always stored in locked cabinets in people's rooms. We observed a medicines administration round and saw that the senior carer carefully administered the medicines required and recorded medicines given on people's medicines administration records. We saw that one medicine was dropped onto the floor and the member of staff continued to administer this medicine rather than disposing of it in line with best practice guidelines. We also saw that the medicines trolley was sometimes left unattended and unlocked during the medicines administration round.

Staff could describe the signs that may indicate when people might need their 'as required' medicines to manage treatment such as pain relief. We found that medicines records did not always clearly outline when 'as required' medicines should be given. We found that there were some gaps in medicines administration records and stock levels of medicines did not always match the amount stated in records.

We looked at the checks that were completed for staff members to ensure they were suitable to work at the home. We found that some checks including references and checks on potential criminality were not always completed prior to a staff member starting work. In some cases the staff member's most recent employer had not been approached for a reference. Where the result of a

Requires improvement

Is the service safe?

pre-employment check needed to be reviewed to decide on a staff member's suitability for the position, the provider could not demonstrate that they had completed a review and that risk had been appropriately assessed.

We found that some bedrooms within the service had a very strong odour; two bedrooms had a strong smell of urine. During the inspection the carpet was cleaned in one of these bedrooms and staff advised that there was a plan to replace this carpet. Another bedroom had a urine bottle on the side which staff told us had been requested by the person as a preference to using the en-suite toilet. Best practice guidelines were not followed with regards to infection control, including the use of a colour coded system for cleaning equipment such as mops. There were areas in the home that were not clean and well maintained. The deputy manager advised of a maintenance programme that was underway and we saw the maintenance person completing work during the inspection. We saw that staff were using protective equipment such as gloves and aprons appropriately during the inspection.

We found that risk assessments were in place but were not always updated or consistently reflected people's needs. We saw that some risk assessments identified the need for walking aids to be in place and we saw these aids being used. However, we found an example of a risk assessment not being in place for the use of a hoist for one person. This person had been identified as someone that sometimes refused the use of equipment to keep them safe. Another person's risk assessment still reflected concerns around their mobility following a fracture that the deputy manager confirmed was out of date. Accident records were not always maintained and the provider was unable to locate specific records of accidents and incidents that had occurred in the service.

People told us that they felt safe living at the service. One person told us "If I didn't feel safe, I would speak to a member of my family but I am happy here", another person told us "I feel safe day and night". Visitors also told us that they felt their relatives were safe. One visitor told us "We can sleep at night with [person's name] being here" and "[Person's name]'s not scared of anyone here. [Person's name] has got enough capacity to know if [they] didn't' like something." Staff could tell us how they would recognise potential signs of abuse and how they would report these concerns. The service had a whistleblowing policy in place although staff were not sure when we spoke with them where they would report concerns outside of the service if this was required.

We recommend that the provider refers to the NICE guidelines 'Managing medicines in care homes' published March 2014 and the Department of Health Code of Practice on the prevention and control of infections published July 2015.

Requires improvement

Is the service effective?

Our findings

People's health and human rights were not always protected through the effective use of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found that one person had refused 15 doses of a medication that had been prescribed by their GP to control swelling. Staff identified during the inspection that this person needed monitoring due to swelling of their ankles. This person was identified by staff as having reduced capacity to make their own decisions about their care. Staff had not followed the steps of the MCA and taken a decision in the best interests of this person as to how they could continue to take their medicines in order to protect their health.

We found that another person who had been identified by staff as not having the capacity to make decisions around their care had refused to wear their safety belt on their wheelchair. This was identified as a risk in their risk assessment. An action was outlined in the risk assessment to manage this risk as speaking to the person to inform them of the risks due to their refusal. Staff and the deputy manager confirmed that this person did not have the capacity to understand the risks. The principles of the MCA had not been followed and a decision had not been made in this person's best interests as to how to keep them safe when they refuse to wear their safety equipment. This person also had bed rails in use in order to keep them in bed at night. The deputy manager confirmed that this person was not able to consent to having this equipment in place, however, again the MCA had not been followed and a best interest decision had not been completed.

We found that staff were administering all medicines within the service. Where people did not have the capacity to consent to this practice, the principles of the MCA had not been followed and best interest decisions had not been made. We confirmed with the deputy manager that there were no current capacity assessments and best interests decisions completed any people who lacked capacity to make their own decisions. We found that managers and staff were not able to fully explain the principles of the MCA and how decisions should be made in people's best interests where they lacked capacity. We found that not all staff had up to date training in the areas of the MCA and associated regulations.

Where people had the capacity to make their own decisions around their care, staff were able to describe how they should obtain consent. We were given examples of how staff would help people to understand decisions and consent to their care. These examples weren't always reflected in the care practice that we saw. For example, we saw a member of staff brush someone's hair without first obtaining their consent. We also saw a member of staff put a clothing protector on a person before they ate. The staff member told the person what they were doing but did not ask if this was something that they wanted.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014 Need for Consent.

We also found that where people were deprived of their liberty in order to protect their safety or well-being that the required legal applications had not been submitted to the local authority. For example where restrictions such as bed rails were in place. People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

Most people told us that they thought staff had the required skills to support them effectively. One person told us "They look after me well so I presume they know what they are doing." A relative told us "I think that the staff are trained to care for [person's name]'s needs." Another relative told us that they did not think that staff had the required training. They said "It doesn't seem like ongoing training is done and dementia techniques." Staff told us that they had regular training and they were currently completing courses in dementia, stroke care and alzheimers. We were told by staff that they were only able to complete certain tasks once they had received training. For example, we were told by staff that they were required to complete medicines training and to have an observed

Requires improvement

Is the service effective?

practice before they were allowed to administer medicines. One member of staff told us that they were, "Learning all the time". Staff told us that they had regular one to one meetings with their manager and they felt well supported.

People told us that they enjoyed the food and drink that they received. One person told us "The food is excellent and there is a choice at breakfast of either cereal or a cooked one and there's a choice at lunch". Another person told us "If I don't like the choice of food or lunch I can have something else, there is always something to eat. I am never hungry." We were told that drinks and snacks were available for people regularly and this reflected what we saw. One person said, "We are always offered drinks throughout the day and biscuits if you want".

We saw that food was cooked freshly on site and was well presented. One relative told us "The food always looks good". We saw that one person required a soft diet and staff told us they were aware of this person's needs. We saw that this person's meal was well presented and the cook told us how important this was to ensure the person can still identify the individual foods. Several people were living with diabetes and the cook explained how these meals are adapted to meet their needs. Staff were aware of people's individual preferences regarding their food and worked to meet their choices.

People told us that their day to day health needs were met well. One person told us "If I am not well I can request the doctor. We also see the dentist and the chiropodist and the optician comes every 6 weeks." We saw that people had regular support from healthcare professionals. We saw during the inspection that people's health needs were observed by staff and outside support was obtained where required. A visiting healthcare professional told us that staff were proactive in obtaining support to maintain people's health where it was required. We were told that staff always follow instructions that are given to them. We were also told that one person wasn't eating or drinking well recently and staff were proactive in contacting the healthcare professional and seeking assistance. Relatives told us that healthcare intervention was sought when needed. One relative told us "I think that my [relative]'s care needs are being met. [Person] was unwell last weekend and the paramedics were called."

Requires improvement

Is the service caring?

Our findings

We found that people's dignity was not always protected by staff. On the first day of the inspection we walked past one person's bedroom. This person was sitting on a commode with their bedroom door open. The staff member supporting this individual had left the person alone while they went to support another person. The staff member told us that they had sought the person's consent to leave them alone and recognised that they should have closed the door to protect their dignity.

We saw that staff spoke about people's needs in communal areas without fully considering their confidentiality and dignity. We saw that staff did not always speak to people in a way that protected their dignity. We heard one member of staff say to someone "Don't do that it's naughty, you've got to be nice." We heard another member of staff say to someone when they had lifted up their clothing "Cover yourself up a bit lady". We saw that people who demonstrated behaviour that could challenge staff weren't always referred to in a dignified way in their plans of care. These people were often referred to as being 'aggressive'.

Staff could describe how they should protect people's dignity by closing doors and asking people discreetly if they needed personal care. We did not see this applied consistently in the care practice we saw. We saw one person on the first day of our inspection shout out that they'd been incontinent. Staff members discussed openly in a communal area that this person needed support going to the toilet.

We saw examples of staff encouraging people to use their walking aids independently. We saw that people were encouraged to stand with minimal support where they were able to mobilise independently and safely. We did however observe two examples where people's independence was not promoted consistently, for example, we saw one person's ablity to mobilise independently was restricted. A staff member was seen supporting someone back to their seat saying "You're not supposed to walk around by yourself in case you fall." Another person was seen struggling to walk independently and staff confirmed that advice had not been sought from occupational therapists to aid this person's mobility.

People told us that they were able to make choices around the care they received. One person told us "I can go to bed when I want. I usually stay and watch television until about 10.30pm. I can have a drink and or food if I wish at that time." Staff told us that they promote choice around people's care. One member of staff told us "They've all got their own opinions about what they would like." We saw that staff offered people choices but this was not consistently done. For example, we observed staff offering a range of drinks during the first morning of the inspection. However, we saw at lunchtime that only cold drinks were offered to people. Staff told us that they only offered cold drinks but if someone asked for a hot drink then this would be provided. We saw that TV channels and music was selected by staff without always asking people what they would like.

People told us that they felt staff were caring. One person said, "The carers are very caring." Another person told us "The staff look after me very well, all I have to think about is what I am going to do next." A relative told us "It is very good care. It was just what [persons name] needed." Another said, "[Person's name] loves the staff. [They're] very well looked after." We saw some warm positive interactions between staff and people living at the home. Staff told us that they were committed to supporting people. One staff member said, "You're there to help, assist and support. You're there to help them and I like doing it." Another staff member told us, "It's a pleasure to work here". The manager told us that they worked to, "Enable our residents to feel like they're in a home from home."

We saw that people were encouraged to maintain relationships that were important to them. We saw visitors coming in and out of the service freely and without restriction. One person told us "I go out with my sister when she comes to pick me up. I enjoy doing that."

Requires improvement

Is the service responsive?

Our findings

People told us that there were some leisure opportunities available however they felt more could be done in this area. One person told us, "I have not been offered anything … to do", "I have a CD player. They would put on the CD for me when I ask, but they forget to come and change it for me." Another person said "There is nothing to do here, it's just the televisions and the radio." A relative told us "There are social activities on Friday evenings and relatives come to socialise." Another relative told us "There's not very many activities."

Staff and management were not aware of these views of people around their preferred pastimes. Staff told us that they got people involved in sing-a-longs, skittles, bingo and playing cards. One member of staff said, "They like what we do." We saw people sitting in the lounge area for long periods of time with no staff interaction or activities. There were two TV's in the lounge that were often both on at the same time and showing different channels. We observed only one example of staff members asking people what they would like on the TVs. One of the TV's was facing away from people towards a doorway of the lounge.

People told us that they were not involved in developing their care plans. Relatives told us that they were involved in care planning. One relative told us, "My [relative] has been involved in [person's name]'s care plan and the reviews. We are quite happy with it." We saw that care plans reflected people's basic care needs and that changes in health needs were communicated during staff handover meetings. Staff that we spoke with were able to talk about the care needs of people living at the service.

We saw that people were supported to observe their religion. For example, staff could tell us how one person liked to pray before leaving their room and carried a bible. We saw that basic likes and dislikes were recorded in people's care plans and were respected by staff. We saw that one care plan said that the person liked having a sing-a-long and we saw this person singing during the inspection. Another person told us that they liked to have a drink and said "I like to have a drink in the evenings.", "I enjoy this very much". We saw that there was a smoking area in the conservatory in which people could smoke if this was their preference. There was no alternative route for non smokers however to exit the lounge into the garden if they did not want to walk through the smoking area.

People told us that they knew how to make a complaint if this was required. One person told us "I have no concerns. If I did, I would know who to complain to." We found that people's comments and complaints were not recorded, however, we were told that where people had raised concerns these concerns had been responded to. For example, we were told that people and their relatives had fed back about the lounge needing to be decorated and this has been responded to. We saw the maintenance person working on redecoration during the inspection.

The provider had not proactively sought people's views. Feedback surveys had been issued during the current year to professionals. Feedback surveys had not been completed during the year with people living at the home, their relatives or with staff. The deputy manager confirmed that the last survey was completed with people at the end of 2014 and this was currently under review to make the format more accessible to people.

Requires improvement

Is the service well-led?

Our findings

There was a registered manager in place at the time of the inspection. At the inspection that we completed in July 2014 we found that the provider was not meeting the regulation regarding assessing and monitoring the quality of service provision. At the inspection completed in November 2015 we found that further improvements were required.

We looked at the processes that the provider had in place for monitoring the quality of the service provided to people and also monitoring and managing risks to people. We found that the provider did not have robust systems in place for ensuring that people received their medicines as prescribed. The provider was not checking people's medicine administration records and checking that people had taken the correct amount of medicine. A monthly medicine audit was completed, however, this did not identify issues that we found during the inspection. We identified issues regarding medicines administration records not being fully completed and stock levels not always matching records. We found that where people had a reduction in their capacity to consent to their own medicines, protocols for people's 'as required' medicines did not clearly outline what signs staff needed to be aware of that would indicate their medicine may be needed.

We found that accidents and incidents were not effectively recorded and monitored. We identified accidents that had arisen in the service and the accident record could not be located. The deputy manager confirmed that there was currently no system for monitoring accidents in order to manage the risks to people. The deputy manager currently relied on care staff to raise concerns around frequent incidents such as falls. We found that compliments, complaints and feedback were not recorded and monitored by management in order to identify issues or trends to improve the quality of service provided and to manage risks to people. We found that where the provider had been required to submit a statutory notification about a significant event to CQC by law this had not been completed.

The provider did not have a clear record of the training that staff had completed. We found that some training certificates were present in staff files but they did not reflect the training that staff told us had taken place. The deputy manager confirmed that there was no formal training record currently kept for care staff and that this would be reviewed. It was confirmed that there was no method in place for ensuring that all staff had received appropriate training.

We found that a care file audit was completed by a member of care staff, however, this had not been completed for several months. We looked at the content of this audit and confirmed with staff and the deputy manager that the audit was not effective in identifying and managing potential risks to people or improving the quality of the service provided to people. As a consequence the provider had no system in place to ensure that they were reviewing the quality of care people were receiving and identifying any potential risks to them.

People living at the home and their relatives told us that they didn't remember having any meetings or being asked to share their views. We saw examples of where feedback had been shared informally. There was no formal system in place to ensure that people's views were obtained and therefore built into the way the provider planned service provision and improvements.

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

People told us that they felt the service was well managed but they did not know who the manager of the service was. One person told us "I don't know who the manager is." Another person told us "I think that this place is well managed but I don't know who the manager is." Staff told us that they felt the service was well managed and that management were approachable. We were told that management had worked with the staff team to create an open, welcoming environment within the service. One staff member said "I love the friendly and kind atmosphere here. It's such a warm welcoming place."

Staff told us that they felt supported in their roles and they felt that management were "Pretty fair". Staff said that they had regular feedback about their performance through supervision meetings and if further support was needed they could just "Ask for a word". Staff told us that they'd been involved in the development of the service. We were told by staff that they had regular meetings during which they could "Talk about what needs to be done. Talk about issues and people's needs."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's human rights were not always protected and upheld through the effective application of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People were not protected by sufficient systems that identified and managed the risks to them. People's experience living in the service was not effectively monitored to promote continuous improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People did not always receive support when they needed it due to the availability of staff at certain times of the day.