Homecroft (Four Oaks) Limited

Wyndley Grange Nursing 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 3 and 8 November 2016 and was unannounced. We last inspected on 28 September 2015. At that inspection we found the provider was meeting all the regulations inspected.

Wyndley Grange provides nursing and personal care and support for up to 64 people. At the time of this inspection 35 people lived in the home. There were two registered managers in post who job shared. 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 the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. 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 brought forward following concerns that had been raised with us in relation to people care needs not being met.

Staff had received training and felt this gave them the skills and knowledge they needed to meet people's needs. Staff understood the different types of abuse and knew what action they should take if they thought a person was at risk of harm.

Although risks to people were assessed, the systems and processes to address these risks were not always implemented to ensure people were kept safe.

People's medicines were not always given as prescribed

Staff promoted people's privacy when they were supported with personal care. People felt staff were kind and had a caring approach to them. People felt involved in making decisions about their day to day care and people dignity and independence was maintained.

Where appropriate people were supported to access health and social care professionals however information was not always recorded to ensure that instructions from other health care professional were followed monitored and records maintained.

Staff did not feel supported or listened to by the management team. Although staffing levels were appropriate and agency staff were used to maintain the staffing levels. Permeant staff felt that the use of agency impacted on people care by not being familiar with people care need. People told us that agency staff did not always know their needs as well as other staff.

The provider had quality assurance and audit systems in place to monitor the care and support people received, but these were not effective and routinely implemented to ensure that processes and procedures were followed. The provider had not identified areas for improvement which we found during our inspection.

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.

People were protected from abuse because staff were able to recognise the signs of abuse and able to raise any concerns they had.

Systems were in place to identify and manage risks associated with people's care but these were not always updated.

People did not always receive their medication as prescribed.

Is the service effective?

Good

The service was effective

People received care to meet their day to day needs and encouraged to be involved in making decisions about their care. Were needed staff would make decision in their best interest.

Systems were in place to ensure that people's liberty was not restricted without the appropriate authorisations.

People were supported with health care needs as required and appropriate referrals were made.

Is the service caring?

Good

The service was caring

People told us that they were well cared for and we saw that the staff were caring and people were treated in a kind and compassionate way. The staff were friendly, patient and discreet when providing support to people.

The staff took time to speak with people and to engage positively with them. This supported people's wellbeing.

People were treated with respect and their independence, privacy and dignity were promoted. People and their families

were included in making decisions about their care. The staff in the home were knowledgeable about the support people required and about how they wanted their care to be provided.

Is the service responsive?

Requires Improvement

The service was not always responsive

People were involved in all decisions about their care and that the care they received met their individual needs.

People were able to comment on their experience of using the service and
were confident that they could speak with staff if they had any concerns.

Some aspect of peoples health was not always monitored effectively which may place people at risk.

Is the service well-led?

Requires Improvement

The service was not always well lead

Although there were systems to assess the quality of the service provided in the home we found that these were not always effective.

Records management in relation to the care people received did not demonstrate that all information was up to date so staff had currently information about people care needs.

Staff did not feel that management listened to their views.

People and their relatives were happy with the care provided.

Wyndley Grange Nursing Home

Detailed findings

Background to this inspection

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

At the last inspection on 28 September 2015 the service was rated was rated as Good. We brought this inspection forward because we had received information to suggest that the service provided to people had declined and peoples' needs were not being met. The inspection took place on 03 and 08 November 2016. The inspection was unannounced. On the first day of our visit the team consisted of two inspectors, a pharmacy inspector an 'expert by experience, and a special advisor. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of care service. A special advisor is a person who has experience in clinical nursing. We told the provider that we would be returning on 8 November 2016 to complete our inspection. On the second day of our inspection the team consisted of two inspectors.

We reviewed the information we held about the service. This included information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. Commissioners had completed a previous visit to the home and the provider was working toward the commissioner's action plan. We reviewed statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send us by law. Notifications had been sent to us in a timely manner.

We spoke with nine people who used the service, twelve relatives, ten staff, both registered managers, the clinical lead nurse and observed the care provided to people. We spent time with people and observed the care and support they were given by staff using a Short Observational framework for inspection (SOFI) in the communal lounge area. SOFI is a way of observing people's care to help us understand the experience of

people who live there.

We reviewed a range of records, these included eight people's care records, six staff records, complaints, accidents and staff meetings, and nineteen medicine administration records (MAR). We looked at quality assurance audits and the feedback the provider had received about the quality of the service provided.

Requires Improvement

Is the service safe?

Our findings

Some risks to people had been assessed and advice from healthcare professionals had been sought to minimise identified risks. For example, where people had been assessed as been at high risk of developing skin damage we saw that pressure relieving equipment was in place and advice was sought from the Tissue Viability Nurse to inform the care plan and prevent skin damage. Documentation showed that where people were being cared for in bed they were regularly repositioned so the risk of skin damage was minimised. Risk assessments were in place for people that were prone to falls. Clear instructions were recorded to say how to manage the risk of falls, such as referrals to fall clinics, lowering of beds and the use of crash mats. Staff spoken with were able to tell us how they supported people to ensure that the aids were in place so people were less at risk from injury. However we saw that where bed rails were in place risk assessments had not been completed for the use of bed rails to ensure that the risk to the person were managed. Where people were unable to use their call bells to summons assistance and were cared for in their room the records did not show how often people needed to be checked or when the person was been checked to ensure that they were safe. Staff told us that people were checked regularly throughout the day and night and this was confirmed by repositioning charts seen.

We saw that where people had repetitive behaviours that staff found difficult to manage the staff had become complacent and did not take actions they would usually take. For example one person had a behaviour that meant they often placed themselves in a particular place in the home. We saw that staff made assumptions that the person had placed themselves in this position and did not consider if there were other causes as to the reason why the person was in that position, so that they could make appropriate checks that the person was not hurt.

People who had been prescribed medicines on an as and when required basis might not have had these given as prescribed because the information to show staff how and when to give these medicines was either not kept or lacked sufficient detail to enable decisions to be made. This included advice when using medicines to help manage a person's anxiety or aggressive behaviour. In addition, one person was being administered medication on a regular basis, even though it was prescribed as "when required" medicine. This meant staff had not administered this person's medication as prescribed. We were unable to determine if the person had experienced any ill effects from this practice and bought it to the attention of the registered manager, who agreed to ensure that the medication was given as prescribed.

Staff monitored the temperatures of the clinic rooms where medicines were stored. Medicines requiring cold storage were kept within two monitored refrigerators in the treatment rooms. Staff had not taken appropriate action after temperatures were documented outside the maximum range in both refrigerators. This meant there was a risk that people could have been administered medication that was no longer effective.

Staff kept records of stock levels of the rest of the medicines. Therefore, staff knew when stock was low and could reorder further supplies and prevent missed doses. Staff wrote the 'date of opening' on oral liquid medicines, insulin pens, and eye drops. This meant that staff knew when these medicines had expired and

needed to be disposed of. Nurses returned unwanted medicines to the pharmacy for disposal at the end of each month. Staff kept records of all medicines that were disposed of.

Staff handwrote medicine administration charts (MAR) charts for new people until the pharmacy could supply a printed MAR chart. Staff signed all the MAR charts to record that people's medicines had been given. This provided a level of assurance that people received their medicines safely, consistently and as prescribed.

People's allergies were recorded so the risk of the allergies occurring was reduced. One person who was prescribed medicines that required regular monitoring had those tests and people on time dependent medication were given them at the correct time intervals. Although carers administered creams to people, nurses signed the MAR charts after witnessing the carers apply the creams. Nurses used patch application record charts to record where they applied the patches to people. This enabled staff to rotate the sites of application as per guidance.

People spoken with told us that they felt safe living at the home. One person told us, "I feel very safe.'' Another person told us, "I have never been so safe in my life.'' A relative told us, "The signing in and out and the buzzers are measures which make us feel that [relative] is safe.'' Another person who used the service told us, "There is no doubt I feel safe.'' Relatives told us that they felt their family members were well looked after and safe. One relative told us, "I go every week I have no concerns about [named person's] safety at all.'' Another relative told us, "I am kept fully informed and very much involved in [named person's] care and I can assure you that [named person] is safe, both in the home and with staff.''

Staff spoken with had a good understanding about their safeguarding responsibilities and was confident about their role in keeping people safe. Staff told us if they had concerns or suspected abuse they would report their concerns to the registered manager or external agencies. Policies and procedures were in place for staff to follow if they suspected harm. Training records showed staff had been trained in being able to recognise the different types of abuse and take actions if they suspected abuse was happening. At the time of our inspection there was an on-going investigation into an allegation of abuse by one of our partner agencies. Although we had been verbally notified by the provider we had not received a formal notification as required by law.

Staff told us that that appropriate checks were undertaken before they began work. We saw criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). There were also copies of other relevant documentation, including employment history and character references in staff files, to show that staff were suitable to work in the service. However for staff who worked with an agency and who were taken on as a permanent member of staff references were not obtained from the agency. We discussed with the registered manager that this would indicate that this was their last employment and a reference should be taken.

People told us they felt that there was always enough staff around but there were too many agency staff. One person told us, "They [agency] don't know us as much as the other staff but there ok.'' Another person said, "They [agency staff] come and go, don't bother me really.'' staff. us, "Usually there is enough staff around. They respond as quickly as they can.'' Another person told us, "Staff are busy but they make time, I have never felt rushed by anyone." A relative told us, "Staff are always about. I can always find one very quickly so I don't think they are short staffed at all.'' One staff member said, "There are plenty of staff, I wish more of them were our staff rather than agency but it's okay. ''

The registered manager told us, "We use a system for calculating staffing levels based on people's

dependency levels. The agency staff are used, with a view to becoming permanent members of staff. The system is called 'temp to perm', which means they [staff] start as agency workers and if the staff member is suitable then they make them permanent. This allows us to ensure that the right person is employed, so although we use agency it is to ensure that the right staff are employed because we have the opportunity of seeing how they work some staff had been recruited as a result of this scheme.''

Good

Is the service effective?

Our findings

People told us that staff involved them in their care. One person who lived there told us, "I feel involved I can talk to anyone about my care or if I have any concerns.'' A relative told us, "I am kept informed about [named person]." Another relative told us, "I have no issues, staff are pleasant, there is no unkindness and I visit twice a week.'' Another relative told us, "Very attentive to people, [relative] has been at the home for two years. I listen to staff when they are speaking with other people and have no concerns about the way staff support people.''

People told us that the care they received was good and that staff were knowledgeable and confident in their roles. One person said, "I think it is excellent here, the best care I have had is here.'' Another person said, "The staff are well trained, they all work really hard." A relative said, "The staff are well trained and they seem to have a genuine interest in people.'' Staff told us that they had training to enable them to support people with their care. We saw that people were being cared for in a way that showed that staff had the skills to meet people's needs. For example when staff supported people to transfer using a hoist..

Staff confirmed that they received supervision from a line manager on a regular basis. These provided staff with opportunities to reflect on their practice and identify future learning needs and career goals. One member of staff described how they had been encouraged to progress to a more senior position in the home with support and appropriate training. Another staff member told us they were encouraged to complete a professional qualification and were supported by the provider as the registered manager had reduced their hours so they could attend college to gain this additional qualification.

The home had a policy in place to guide staff in procedures relating to 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. 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 procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS). One staff member described the principles of the MCA as, "Encouraging people to make their own decisions and not forcing someone to do something that they don't want to do." People's records included signed permission forms that they had signed to give their consent to care and treatment. We observed that staff frequently checked that people were consenting to their care, for example a staff member was heard to say, "Shall we go to the bathroom and change your top.'' Another member of staff was heard to say, "Shall I look at your hand'' when they saw the person continually itching it. We saw that a number of DoLS applications had been made and authorised. Staff spoken with were aware of the people who had a DoLS authorisation in place and were clear about the restriction imposed.

We observed at the lunch time meal that some people required support to eat their meals and staff were available and supported people who need this. We saw that some staff held a conversation with the individual but other staff did not interact with people while they were supporting them. People spoken with

were positive about the food. One person told us,"The food is always good, filling and tasty." Another person told us, "I can change my mind if I don't like it.'' We saw that people ate their meals in the lounge or their bedrooms during lunch time. People tended to eat their meal where they were sitting. This was the same for breakfast and tea. The home has two dining areas, but we did not see people being encouraged to use this facticity. Staff told us that people were asked but they often refused. We spoke with three people about their meal time experience who confirmed that they were asked if they wanted to go to any of the dining areas. All three told us if there was a dining table in the lounge then they would use it but did not want to go down stairs or across to the new building where the dining areas were situated so preferred to eat their meal where they were.

People told us told us they were supported to see their GP, attend hospital appointments, or appointments to see other healthcare professionals such as the dentist or chiropodist. A relative told us that staff always let them know if they had any concerns about [the named person] and felt that the staff were very prompt in making referrals if needed. One relative told us, "[named] person was not their normal self and staff were not happy, so contacted the doctor, which resulted in an admission to hospital, I trust the staff to make such decisions, because they were spot on.''

Good

Is the service caring?

Our findings

People spoken with told us and we saw that people were positive about the care provided. We saw that people were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. One person who used the service told us, "I am treated well.'' Another person told us, "There very caring and very patient.'' A third person told us, "I haven't come across anything which is not right. One relative told us, "They are very obliging.'' Another relative told us, "They [staff] are compassionate and caring, there are always plenty of staff.'' A third relative told us, "They [staff] treat my [named person] with dignity. I cannot fault the care. It is really good.''

People told us that the staff asked them about how they wanted to be cared for and supported when they first moved into the home. They said that staff checked with them before providing physical care and respected their choices. Many people were able to engage with staff and we saw staff checking and asking people what they wanted them to do before proceeding. We saw where people were unable to fully convey their care and choices staff repeated what they were doing and gave them the opportunity to make a choice. People told us that staff respected their privacy and took care to ask permission before entering their rooms.

Staff were able to tell us about people's personalities and priorities and they spoke with affection about the people they cared for. They had a good knowledge of people's situations and their preferences in terms of their care and support. Staff were aware of how people preferred their needs arising from their culture, religion or health conditions to be met. We saw that people were given the opportunity to be as independent as possible for example asking people who needed support to mobilise to move to the end of the chair and then they were supported to stand with minimal assistance. One staff member told us, "We encourage people to be as independent as possible even if it's undertaking small task for themselves.''

The staff provided examples of how they had worked with specialist nurses and hospice staff to ensure that people had been enabled to experience personalised and dignified care at the end of their lives. This included involving and accommodating family members. Where people had been willing to discuss their preferences in relation to the end of their life, staff had recorded this information. We saw that protocols were in place that gave staff a list of instructions and very informative information about people's wishes which was evaluated monthly with the person. The service was working towards The Gold Standard Framework in formulating end of life care for people that involved family members.

Requires Improvement

Is the service responsive?

Our findings

Staff spoken with demonstrated their knowledge about people's individual care needs. Each person had support plans in place which provided guidance for staff about how best to meet their needs. We saw that care records were being transferred to a new system so information was contained in one place for easy access. The staff told us that at the beginning of each shift the nursing staff had a handover so they could discuss any changes in people's care needs, we looked at the handover sheet and saw that information was passed over when staff came on duty so staff had the information about changes to people's needs. However we saw examples where this information was not always recorded. For example., Some people required their fluid intake to be monitored to ensure that people were having enough to drink to keep them healthy. We saw that people were offered drinks throughout the day. We saw that drinks were available in communal area, and fluid monitoring chart were available so staff could recorded what people had so action could be taken if people were not drinking enough. However, we found staff did not consistently complete these so information would not be accurate to make the appropriate referral if needed.

We saw that staff continually asked people about their care and the support they wanted. One person told us, "They [staff] make sure I am okay with what they are doing and I have no problems with what they do for me.'' Relatives told us that the staff kept them informed about their relative's care and contacted them when needed. Relative's told us that they were invited to reviews of their relative's care and where their relative was able to take part they did. We saw that people's families were involved so that support could be given in the way they would have liked. People were supported to maintain contact with friends and family. However we saw that advocates were not utilized to support people who did not have relatives. Some people with fluctuating memory or sensory loss did not have easy access to communication aids. For example one person had a hearing impairment, although the person had communication cards they were not accessible and we had to request that these were given to the person so we could communicate with them. The person told us staff understood their needs. However this showed that the communication aids were not routinely given to individuals as part of their daily routine to communicate their needs.

Although people's primary care needs were nursing the home is registered to support people living with dementia. We saw that various different coloured signs were in place throughout the building to give people guidance of their whereabouts, activities like reminiscing took place. Staff told us and we saw that staff had received training in dementia care and saw that staff put this into practice during the visit. For example we saw staff speaking with people about the past, the war, and when one person became concerned, a staff member sat with the person talking about cars as this was what the person liked. This resulted in the individual becoming clam. A relative told us, "Staff ask me about [named person's] care, what they used to like doing, what food they liked and what activity they liked. As mom has deteriorated with dementia they still do what I have told them, so I am very happy with mom's care.''

The service employed two activity co-ordinators who planned a weekly timetable of activities based around interests of people who used the service. People spoken with shared their hobbies and interest with us and told us what they enjoyed doing. These included gardening, visit to National Trust venues, musical theatres and cooking. People told us that activity took place such as quiz's and events in the summer, such as garden

parties and trips. We observed that the quiz was not well organised and people appeared unengaged. The activity coordinator told us afternoon activities were focused on people who remained in their rooms with one to one activity depending on their preference. We saw one activity for a person living with was reminiscing at the relative's request. Some people were reading newspapers and told us this was their choice. Relatives we spoke with said they were able to visit at any time and were always made welcome. Relatives told us they could stay as long as they wanted to and were invited to be involved in any activity that took place.

There was a complaints policy and procedure in place that outlined the procedures to follow should people need to complain. People spoken with told us they would tell staff if they wanted to make a complaint. A relative told us, "[Name of person] had a problem last year and it was very quickly sorted, management were very responsive. I have no hesitation if there is something I what to discuss because they [staff] and management are willing to listen and resolve any concerns or worries I might have.'' At the time of our inspection a complaint had been made. The registered manager told us an outcome had not been sent to complainant because there was an on-going investigation.

Requires Improvement

Is the service well-led?

Our findings

We received a mixed response from staff when we asked them if they felt supported by management. Some staff told us that the management was approachable and always listened to suggestions and that the management did all they could so staff could progress further in their career. However, some staff told us that they did not always feel supported by the management, there was favouritism towards some staff, and that issues were not discussed in a transparent way. Some staff said they did not always feel valued and their contribution and experience was not taken into account. Some staff reported that they would not approach the management with ideas and suggestions about improvement as they did not feel listened to. Some staff told us that they felt intimidated by other staff members and when they reported this to the management nothing was done. This showed that there was not a clear, transparent and open culture in the home where staff felt valued and able to raise concerns. Staff told us that there had been a high turnover of staff because staff felt devalued which has resulted in using agency staff. The registered manager told us that twelve members had left the organisation; the registered manger told us that they completed exit interviews which were recorded. However the one exit interview we saw was very brief and did not identify why the staff member was leaving.

People and their relatives who we spoke with told us that they felt the staff and management was responsive, and felt comfortable approaching them with any issues they had. One person who used the service told us, "I can approach them [registered managers].'' Another person told us, "They [registered managers] are very approachable.'' A relative told us, "I have found them [management] alright, the home is clean and well run they cater for my dad's need.'' Another relative told us, "I have never had a problem in the two years since mom has been here. Staff are on the ball with her health care needs, feels like management are open.'' Another relative told us, "Staff are willing to listen. I have spoken with management who are always approachable.'' This shows that although there was dissatisfaction in the staff team people and relatives were happy with the staff and managers.

Systems were in place to monitor the quality of service the provided. While some of these systems were effective we saw that this was not the case for all aspects of care provision. For example the systems had not been effective to ensure that information about people and their care needs was recorded consistently. Some of the care records showed that information was not updated when other visiting professionals gave instructions, so current information was available for staff to ensure people's care needs were met. This meant that there was a risk that people may not receive care that followed health care professional's advice. The registered managers told us a new system for care planning was being used, however time had not been set aside so all the information was transferred which meant that staff were working with two care record systems and information and dates were not recorded. This may cause information to be lost which could have an impact on people's care. Staff told us and we saw that verbal communication about people's care needs was used. Staff told us they did not always have the time to record information.

The providers systems to monitor the quality of care provided had not identified this shortfall. The registered managers did not utilise care staff experience to support the nursing staff. For example, care staff told us that they were not in involved in people's reviews. One care staff told us, "We know more about people than

the nursing staff, the nursing staff do the medical bits, but we know the personal details about them. For example, if you asked a nurse about how a person likes their pillows they would not know.'' We shared this information with the provider who felt that by doing involving care staff in the reviews of people care would benefit the nursing staff and ensure care was more personalised.

The registered manager told us that a new system of care planning and risk assessment planning was being implemented that would be more effective for staff to use. A complete evaluation of people's care needs was being completed and had commenced. The new system looked at demonstrated that information would be more concise, but this had not yet been fully imbedded to complete a full assessment.

During our inspection we saw people were not always protected from risks of acquired infections. We saw that the service used a satellite kitchen in the main building where breakfast and tea time meals were prepared. We saw that there were no cleaning schedules for the satellite kitchen and the equipment that was being used was dirty. For example there were no records of temperatures for the fridge which was compacted with ice, tiles were cracked, extractor fans were dirty and one piece of equipment was rusty. We saw that the provider focused had been made on the new kitchen in the new building which met all the required standard in respect of infection control. These issues had not been picked up through the provider's monitoring systems. The registered managers took immediate action and closed the kitchen when we identified the however, if the systems in place to monitor the service were effective then this action would not have needed to take place. On the second day of our visit the provider had purchased new equipment and a deep clean had taken place.

There were two registered managers in post undertaking a job share who registered with us in October 2015. 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 the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Both registered manager were aware of their responsible however the monitoring of the service had not been effective in identifying the shortfall we found during our inspection. The provider had acknowledged that the quality of the care in some incidents had not been as good as the standard they aspired to and as a result of the concerns raised they had voluntarily agreed with other statutory agencies to suspend any further placements into the home until they could improve the quality of the service and address the shortfalls identified. An action plan was in place to address the shortfall which had commenced with the employment of a qualified nurse with extensive experience to become the registered manager. A consultant who has experience in nursing homes and nursing care had been appointed to put effective monitoring system in place. Staff meetings were taking place so staff had the opportunity to discuss their concerns on a two weekly basis.