Woodlands Care GRP Ltd

Woodlands House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The unannounced inspection took place on 12 July 2016. The last inspection was undertaken on 20 May 2014 and the service was meeting all requirements reviewed at that time.
Woodlands House is registered to provide residential care for up to 38 adults. The home specialises in the care of adults with varying levels of dementia and complexity in needs. The home is situated in a quiet residential area, located off the main Atherton to Bolton road. There is a large garden to the rear and car parking available at the front of the home. It is located close to local amenities.

There was a registered manager at the service. 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.

On the day of the inspection there were 35 people living at the home. There was one vacancy and one person currently in hospital.

The service had a robust recruitment system in place and staffing levels were sufficient to meet the needs of people who used the service.

There were appropriate individual and environmental risk assessments in place. Staff were aware of safeguarding procedures and confident to report any concerns.

There were systems in place to help ensure medicines were ordered, stored, administered and disposed of safely.

Regular quality audits were undertaken and issues identified and addressed by the service.

The induction programme was robust and included all mandatory training. Staff had regular supervision sessions and annual appraisals and further training and development was on-going.

Care plans included a range of health and personal information. They were person-centred and people's preferences, likes and dislikes were documented.

People's nutritional and hydration needs were catered for and the environment was suitable for people living with dementia.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

People who used the service were well presented and well cared for. Relatives and professional visitors told

us staff were kind, respectful and caring.

The service ensured equality and diversity was respected. Privacy and dignity was also respected.

Residents' meetings were held regularly to ascertain people's views and opinions and information was produced in the form of the service user guide.

The service endeavoured to support people to stay at the home when they were nearing the end of their lives if this was their wish.

There was a range of activities on offer within the home and the service linked in with the wider community to help keep people integrated within society.

There was an appropriate complaints policy in place which was prominently displayed within the home.

The manager attended a number of local care home meetings to keep up to date with changes.

Regular team meetings took place and staff feedback was sought through regular questionnaires and listening groups.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There was a robust recruitment system in place and staffing levels were sufficient to meet the needs of people who used the service.

There were appropriate risk assessments in place. Staff were aware of safeguarding procedures and confident to report any concerns.

There were systems in place to help ensure medicines were ordered, stored, administered and disposed of safely.

Regular quality audits were undertaken and issues identified and addressed by the service.

Is the service effective?

Good

The service was effective.

The induction programme was robust and included all mandatory training. Further training for staff was on-going.

Care plans included a range of health and personal information.

People's nutritional and hydration needs were catered for and the environment was suitable for people living with dementia.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

People who used the service were well presented and well cared for.

Relatives and professional visitors told us staff were kind, respectful and caring.

The service ensured equality and diversity was respected.

Residents' meetings were held regularly to ascertain people's views and opinions.

Information was produced in the form of the service user guide.

The service endeavoured to support people to stay at the home when they were nearing the end of their lives if this was their wish.

Is the service responsive?

Good

The service was responsive.

There was a range of activities on offer within the home and the service linked in with the wider community to help keep people integrated within society.

Care plans were individualised and person-centred.

There was an appropriate complaints policy in place which was prominently displayed within the home.

Is the service well-led?

Good

The service was well-led.

There was a registered manager at the service.

The manager attended a number of local care home meetings to keep up to date with changes.

Regular staff feedback was sought via questionnaires, meetings and listening groups.

Woodlands House

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.

The inspection took place on 12 July 2016 and was unannounced.

The inspection was undertaken by two adult social care inspectors from the Care Quality Commission (CQC).

Prior to the inspection the service completed a Provider Information Return (PIR), which is a form that asks the provider to give some key information about the service. We also reviewed information we held about the home in the form of notifications received from the service.

As part of the inspection we spoke with the registered manager, the deputy manager, three members of care staff, three relatives and two professional visitors. We were unable to speak to people who used the service as ten people were going out of the home on a trip and those that were left in the home were living with dementia and were unable to tell us their views. We were unable to undertake a Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help us understand the experience of people who cannot not talk with us, as people were in different areas of the home. However, we observed care throughout the home during the day. We looked at three care plans and three staff files and two volunteer files. We also reviewed other records held by the service including audits, meeting minutes, supervision notes and training records.

Good

Is the service safe?

Our findings

The service had a robust recruitment procedure in place. We saw within the staff files we looked at that there were application forms, proof of identification, interview notes, job descriptions, references and Disclosure and Barring Service (DBS) checks. DBS checks help ensure staff are suitable to work with vulnerable people.

Staffing levels were appropriate for the people who used the service. On the day of the inspection the deputy manager was on duty, with four carers, one domestic, one housekeeper and one kitchen assistant. The registered manager was on training course but came back to assist with inspection.

There was a new on call system in place relating to back up staff. This consisted of a member of staff being on call on a particular day to cover for any unexpected staff absence. This had been implemented after consultation with staff and the registered manager told us it was working well.

Appropriate individual risk assessments were in place within people's care files. Environmental risk assessments were also in place to help ensure a safe and secure environment.

We saw evidence of performance monitoring and disciplinary procedures were followed appropriately where necessary.

The service had its own safeguarding policy as well as the local safeguarding policy and procedure. This was readily available for all staff and there was a poster with all the local contact numbers on it. There was guidance for staff on how each person who used the service was funded and incident forms for them to use if required. All safeguarding training was up to date and staff we spoke with demonstrated an understanding of safeguarding issues and how to report these. Safeguarding notifications were sent in to CQC as required. There was a whistle blowing policy so that staff were able to report any poor practice.

The service had CCTV in place in the communal lounges, the use of which had been discussed with people who used the service and their relatives. Information about the CCTV was also in the service user guide and there were signs at the front door indicating that CCTV was in place. The CCTV was used to track unwitnessed falls or incidents when required. There was an appropriate policy in place relating to this and we saw records of when CCTV had been viewed and for what purpose. This helped ensure the CCTV was used appropriately within the home.

We looked at the medicines policy and procedure, a copy of which was in one of the two designated areas for medicines. There was guidance on covert medicines, which is medicines given in food or drink, and new homely remedies guidance so that medicines given as and when required (PRN) could be administered and recorded appropriately. The registered manager told us that PRN medicines could be reviewed if it was difficult to administer them with the required four hours gap, so that stronger, less frequently given, pain relief could be substituted if appropriate.

All team leaders at the service had undertaken medicines training via the local pharmacist service. There

were regular in house medicines audits where any issues were highlighted and addressed to help ensure medicines continued to be administered safely. The local Clinical Commissioning Group (CCG) also undertook audits and observations of practice and issued advice and guidance on changes required. This advice was acted upon by the service.

The home used a system called Biodose. This is where medicines are contained in a 'pod'. Each pod can contain tablets or liquid medication. There was a photograph on the front of each person's medicine record, which helped minimise medication mistakes. We saw that signatures were added to each individual's medication administration record sheet (MARs) as their medicine had been administered. GP letters, around covert administration, were kept in the files. There was guidance on how each person liked to take their medicines, on covert medication pictures of the food and drink to put the medicine in and a description of what each medicine was for so that staff had an understanding of this. One person, who did not speak English, had a sheet in their own language with their medicine to ensure they understood when they were being offered medicines.

Medicines were securely stored and one person was responsible checking the disposal of excess medicines to help ensure consistency and minimise the risk of mistakes. The room temperature was regulated with an air conditioning unit to ensure it was correct for the storage of medication and fridge temperatures were taken daily to ensure they were within the manufacturers' guidelines.

We saw that the service had information around infection control, including how to deal with any outbreaks. The service had scored 95% in a recent infection control audit, demonstrating a high level of compliance with all aspects of hygiene, cleanliness and infection control issues.

Accidents and incidents were documented appropriately and regularly audited to identify any patterns or trends. Similarly there was analysis of falls sustained to look at underlying causes and ensure appropriate responses.

The service had equipment for people who used the service, such as wheelchairs and mobility aids. Equipment was used appropriately and maintained regularly. We saw monthly audits relating to equipment and service contracts were in place. Any issues relating to equipment were noted and addressed.

Good

Is the service effective?

Our findings

An ancillary member of staff we spoke with told us, "People are well presented. Although staff are always busy people are not left to wait long if they need assistance". A health professional visiting the service said, "There is always an appropriate handover from staff. They [staff] seek out and listen to advice. They monitor and help build up weight where required". A GP who visited two or three times monthly told us, "Appropriate referrals to our service are made. Staff are competent in assessing patients, triage for us and fax good information. Care notes are meticulous and there is a positive relationship between their service and ours".

Hard copy care plans were detailed and included a range of health and personal information. This consisted of next of kin details, social history, current medication, medical history, homely remedies, any incident reports, choices and preferences. Do Not Attempt Cardiopulmonary Resuscitation (DNAR) forms and advanced care planning documentation was also included where applicable. Personal Emergency Evacuation Plans (PEEPS) outlining the level of assistance needed in an emergency situation were also kept within people's care files. Some risk assessments for daily use and observation were in the files, for example dealing with inappropriate behaviour.

The home worked with a system, CoolCare and a more detailed care file was held on this system which all staff had access to so that notes and amendments could be added. General risk assessments were on this system. On the day of the inspection the team leader was seen completing notes following a visit from a GP.

Hospital transfer forms, including medical and personal information were kept on computer. These were used when people were taken into hospital to help ensure continuity of care.

There were also 'lounge files', kept in the particular lounge area each person preferred to use. These included a photograph and pen picture of each person, any special dietary requirements or weight monitoring, allergies (highlighted in red), and PEEPS. A pen picture file was also held in each bedroom so the staff could see very quickly what care and support was required. A pictorial representation of a floral heart was placed discreetly in people's rooms to help staff by indicating that a DNAR was in place.
The induction process was robust, new employees having orientation around the home as well as completing the Care Certificate over a number of weeks. The certificate has been developed by a recognised workforce development body for adult social care in England. The Care Certificate is a set of standards that health and social care workers are expected to adhere to in their daily working life.
We looked at the training records and saw that staff were up to date with all mandatory training, such as safeguarding, moving and handling, health and safety. A number of other courses, including catheter care and diabetes, conflict resolution and various dementia courses had also been undertaken by large numbers of staff. Most training was delivered 'in house' but the registered manager told us that outside training, via district nurses, infection control team or other agencies was sought when required.

There were champions amongst the staff in the areas of dementia, dignity, end of life, sparkle and reminiscence, infection control, cleanliness and tidiness and continence. These members of staff were

responsible for the oversight of their particular area.

Staff supervisions were undertaken every 8 – 12 weeks, some being individual supervisions and others group sessions. Some supervisions were undertaken following training sessions to check out staff's understanding and knowledge of the subject. Staff appraisals were undertaken on an annual basis to discuss their progress and future development needs.

The service used an outside catering firm to supply their meals and the registered manager told us people were very happy with this food. Volunteers who regularly worked at the home carried out food tasting on a regular basis. We saw that they had completed questionnaires about the meal time experience, the food, and staff interaction. Issues identified, such as the need to have condiments on all tables, had been addressed promptly.

There were two kitchen assistants employed who were available throughout the day to supply snacks and drinks, serve the meals and ensure people's dietary requirements were adhered to. We saw that alternative menus, such as omelettes, sandwiches, fishcake and beans, soup, quiche and salad and jacket potatoes with various fillings were available for anyone who did not wish to have one of the two choices of meals supplied. These were represented pictorially to help people with making their choices.

The service followed the Feelings Matter Most model of dementia care, founded by David Sheard, a leading researcher in dementia care. The environment was decorated with lots of themed areas for people to focus on. There was a garden room which led out to a safe and secure garden with raised planters, plenty of colour and aromatic smells. There were safe, tactile items around the home for people to pick up as they wished. There was clear signage within the home to help people with orientation. The home is not a purpose built home and is 'rambling' however it has been adapted and space utilised as best it can be.

We saw that consent was sought from people who used the service, or agreement to a best interests decision by their relatives, for issues such as using photographs, agreement to the use of CCTV and being included on the service's social media. Some people had refused to be included in the social media and these wishes had been respected.

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 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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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. Staff had received training in MCA and DoLS and demonstrated an understanding of the principles of MCA and DoLS. We saw evidence of best interests decisions being made for people who lacked capacity, which had been contributed to by the relevant professionals, family members and/or friends.

Appropriate referrals had been made for DoLS authorisations and these were reviewed and renewed as required. We saw that details of people who were subject to a Deprivation of Liberty Safeguards (DoLS)

authorisation were included within their care files and also in the lounge files. This was represented pictorially with a bird in a cage and the restrictions used, such as mats, constant supervision and key pads was noted.

Good

Is the service caring?

Our findings

As there were ten people who used the service on a trip to Southport on the day of the inspection, we were unable to gather the views of people who used the service. The people who were left in the home were unable to express their opinions via verbal communication. However, we spent a considerable amount of time observing care and interaction in various areas of the home and people's body language demonstrated that they were content and happy. Staff interactions were polite, respectful and friendly and they were patient and kind when delivering care interventions and people responded with smiles and a relaxed manner.

We saw that people's privacy and dignity was respected. We heard staff explaining what they were doing when offering assistance to people. The home's dignity and continence champions also helped ensure people's dignity was respected by leading other staff in these areas and ensuring people's care was delivered with dignity in mind.

We observed that one person who used the service was distressed when coming out of her room. She expressed that she was worried about the jumper she had on. We saw that this person was gently assisted back to her room by staff and reappeared wearing a different jumper and was much happier.

A visitor we spoke with told us they were always welcomed and offered refreshments on arrival at the home. They went on to say "[Relative's] room is perfect, we have personalised it with photos and ornaments. [Relative] has settled really well and does not mention going home." Two other relatives we spoke with said they were 'delighted' with the home, "Can't fault the place. The staff let us know if [relative] is not well and that they have called the GP".

An ancillary staff member said, "It [the home] is lovely. The staff do their best with some difficult service users. Staff are very patient and treat service users with respect". A visiting health professional told us, "All staff seem very kind. They are concerned about people's welfare. One person has no family and they [staff] have been so kind".

The service was committed to ensuring equality and diversity was respected. One person who used the service did not speak English. The service had supplied flash cards to use with this person to help ensure they could communicate as well as possible, for example bedtime, meal times, choice of clothes and if they were in pain. A request for this person to take their medicines was written in their own language to be used when administering medication. One staff member was able to speak this person's language and ensured they communicated with them as much as possible. DVDs in the person's first language had been purchased and were played for them when they wanted this. Some special meals were brought in for this person by a family member and the service ensured these meals were given.

Another person, with a different cultural background, lived at the home. Staff had explored the person's religious and cultural needs and supported them to follow their culture as much as they wanted to.

We saw minutes of one of the regular residents' meetings. People who used the service had been asked how they felt about living at the home. Comments included, "Very happy, staff are nice, food is nice but there's nowhere like home"; "Very happy, the carers are lovely"; "Excellent, happy with bedroom"; "Underneath the bed is filthy, cleaned it herself" and "Better than being alone at home".

There was a service user guide in each person's bedroom for them or their families to consult at any time. This included all information about the home, facilities, meals, care planning, nurse call, health and safety procedures, religious services, security and relevant policies, including complaints.

The registered manager had completed the Six Steps training course. This is the North West End of Life Programme for Care Homes. This means that for people who are nearing the end of their life can remain at the home to be cared for in familiar surroundings by people they know and could trust. She had passed on her knowledge to other staff and told us they were supported by district nurses in caring for people as they neared the end of their lives. The registered manager told us that a person who had recently passed away had been able to have their family member with them constantly for the last week of their life. The home had supplied a bed so that the family member could remain in their loved one's room throughout their last days. They had also ensured that the person had been able to have contact with a staff member's dog, with which they had developed a close relationship at the home. These actions had helped ensure the person had experienced as good a death as possible.

Good

Is the service responsive?

Our findings

We saw that there were a number of activities on offer at the home. On the day of our visit ten people had gone on a trip to Southport, supported by off duty staff members. Others were pursuing interests such as drawing, games and singing. One ancillary member of staff told us, "There are lots of activities – games, singing, baking, reading from newspapers and magazines, bingo". A visitor said, "They go in the garden a lot when it is sunny".

The service had set up a 'Friends of Woodlands' group, for which they had secured a large sum of lottery funding. This was used for activities, stimulation (such as the dementia friendly areas in the home) and trips out. A new activity of swimming at the local leisure centre had been accessed recently. A weekly session for people living with dementia had been started and this had been thoroughly enjoyed by people who had attended the first session. The home planned to take different people, who expressed a wish to join in, each time to help ensure all who wanted to go would have the opportunity.

There was also a 'Friends of Atherton' group which the home had links with. The service was using social media to keep relatives and friends abreast of what was happening in the home. This was particularly welcomed by relatives who lived a distance away from the home and were unable to visit as often as they would like as it helped them feel involved with the home. The social media site included positive comments from people who used it.

The service had also made contact with a local hub centre and were taking people to a bingo session there. There were trips into the local town centre or even just to the end of the road to the post box to post their own letters, which helped people feel more independent. There were events, such as a garden party to celebrate the Queen's birthday, regular entertainers, holistic therapy sessions and a number of DVDs for people to watch.

Care plans were person centred and included people's likes, dislikes and preferences. We saw that people were able to state their preferred gender of carer and this was respected.

There was an appropriate complaints policy in place, which was also displayed in the entrance to the home and was outlined within the service user guide. There had been no complaints received by the service in the last 12 months.

The service had received a number of compliment cards from relatives. Comments included, "To all the staff at Woodlands. Thank you for all you did for [relative]. You were so good with her, we can't thank you enough"; "We are truly grateful for the superb care you provided to [relative], particularly over the last few months. You are all so dedicated and caring and have time for all. You have also been patient and kind with us"; "Just a little note to say thank you for taking such good care of [relative]. The care and attention you gave was fantastic. You are all superstars".

Good

Is the service well-led?

Our findings

There was a registered manager at the service. 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.

Staff we spoke with told us they were well supported by the management at the home. One staff member said, "The managers are always there for us. There is plenty of support from the manager and the deputy. We work well as a team, I enjoy coming to work".

The registered manager ensured she kept up to date with the latest research in dementia care and applied her knowledge and learning to the care and environment within the home. She also made sure staff's knowledge and training was current.

The home had excellent links with the wider community via the local leisure centre, local hub, 'Friends of Atherton' group and social media. The registered manager also linked in with the local Care Providers' Forum and Care Home Link meetings to help keep up to date with changes and new ideas.

Quality assurance was undertaken in a number of ways. There were daily walk rounds by the registered manager, observations of practice, audits undertaken in areas such as accidents and incidents, medication, weight monitoring, moving and handling, equipment . Any issues identified were documented and addressed promptly. Volunteers at the service also undertook some quality assurance via meal tasting and regular general reviews of the service delivery.

There was a twice yearly staff questionnaire to ascertain if staff felt the service was safe, using best care, responding to people's welfare and caring. The views of people who used the service was ascertained via residents' meetings as well as on a daily basis via informal feedback.

We saw evidence of staff consultation regarding the new on-call scheme. This scheme meant that there was now always a staff member on-call to provide cover in case of a member of the team ringing in sick. This reduced the necessity to call on agency staff and provided more consistency for people who used the service.

There were regular staff meetings held which offered an opportunity for staff to feedback general concerns, issues and suggestions. Individual supervisions gave staff a forum to speak on a one to one basis and the management had an 'open door' policy so that staff could approach them at any time without a prior appointment.

The director of the service held regular listening groups to gather staff feedback. We saw that areas such as induction and training had been discussed at these groups.

Notifications of events, such as serious injuries, safeguardings and deaths were sent to CQC in a timely way.