Calvercare Limited

Woodlands Park Care Centre

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

Woodlands Park Care Centre provides care and accommodation for up to 35 older people who are living with dementia. At the time of our inspection there were 22 people who used the service.

At the time of our inspection the registered manager had been absent from the service. The service was being managed by the deputy manager with support from the regional manager. The provider notified us of the registered managers absence.

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.

Our previous inspection carried out in December 2015 found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we checked whether the service had achieved compliance with the associated regulations. Following our findings the provider submitted an action plan to ensure improvements were made. We found that improvements had been made at the service.

People were protected against abuse and neglect. Staff we spoke with told us they had completed training in safeguarding and would not hesitate to report any concerns. However, we continued to have some concerns in relation to the gate at the top of the main staircase. Our previous inspection identified this risk and we asked the provider to review the risks in this area. The provider has done this although we would like them to continue to assess the potential risk on an ongoing basis.

Risk assessments were in place for people living at the home. For example, people who were identified at risk of falling down the stairs. Risks were taken into account and risk assessments were in place to protect people. On two occasions we saw that the gate was left open at the top of the stairs. We pointed this out to the deputy manager, who said they would address this with the maintenance staff. The risk assessments we saw informed staff to monitor and assist when people used the stairs.

Medicines were not always administered in line with policy and procedure however; this had been picked up by the audit procedures that the home had in place. Where there were missing signatures on the Medicine administration record (MAR) sheets these were in the process of being investigated. Where there were no printed MAR charts, hand written charts were completed. The home was meeting with the pharmacy to discuss how this practice could be minimised.

We found staffing levels in the home to be appropriate to the needs of people living in the home. The service used agency staff to maintain safe staffing levels. Records showed that agency staff had received a thorough induction on the first day they worked at the service.

The environment was cleaned to a high standard and was tailored for people living with dementia. For example, 'old-time' memorabilia and items of interest such as old-fashioned sewing machines.
The home had a 'daily sparkle'. This was printed information for people to read that had stories about famous film stars from the past that encouraged conversations with people.

Relatives told us how happy they were with the quality of the service and that staff were kind and considerate. One relative told us, "This has been the happiest four years of my life. I can appreciate the care the staff give to my relative."

Staff received supervision and told us they felt supported. However, the frequency was not in line with the company policy which stated six sessions per year.

People's social needs were being met. There was an activity coordinator who provided social activities for people who wanted to take part. At the time of our inspection there were outside entertainers playing music and singing to people.

Quality audits systems were in place to assess and monitor the service.

We have made a recommendation in relation to the potential risks associated with people using the staircase.

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.

Risks were appropriately assessed. Guidance for staff to manage risks was provided.

Medicines were managed effectively and issues were picked up and dealt with through quality audits.

Induction of agency staff had improved and ensured people were adequately protected from staff that were aware of people's needs.

Is the service effective?

Good

The service was effective.

Staff were well trained and motivated to effectively support people.

Staff understood the requirements of the Mental Capacity Act 2005 and people's choices were respected.

Staff were able to prevent people being deprived of their liberty unlawfully.

Is the service caring?

Good

The service was caring.

Staff provided support with respect and compassion.

People's preference for end of life care was discussed and the service enabled people to remain in the home as they wished.

People were provided with appropriate and sensitive care at the end of their lives.

Is the service responsive?

Good

The service was responsive.

Regular planned activities took place and people were empowered to make decisions about how they spent their day.

People and their families were involved in the way their care was carried out.

People and their relatives told us they knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The provider had ensured that appropriate measures were in place to cover the absence of the registered manager.

Quality audits were in place and identified shortfalls in the service, which were then acted on.

Staff were supported by the provider to contribute to discussions about the service and how it operated.

Woodlands Park Care Centre

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 22 and 23 November 2016 and was unannounced. The inspection team consisted of one inspection manager, one inspector, one registration inspector and a specialist advisor. A specialist advisor is someone with specific experience in a particular area. Their area of expertise was in older people's care.

Before the inspection we reviewed all the information we held about the service. We looked at notifications the provider had a legal obligation to send to us. Notifications are information about certain events and changes that affect a service or the people using it. The provider completed a Provider Information Return (PIR) prior to the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with the regional manager, the compliance officer, the deputy manager, and 10 members of staff including agency staff. We also spoke with the local GP, two visiting relatives, the chef, the maintenance person and the activity coordinator. We also spoke with the registered manager who came to the service for a short period to introduce themselves.

We reviewed eight people's care plans, medicines records, checked stock of medicines including controlled medicines, six staff recruitment files, audits and minutes of meetings. We also looked at accidents and incidents relating to the service.

We also spoke with the local authority following our inspection.

Good

Is the service safe?

Our findings

At our previous inspection in December 2015 we rated this key question as inadequate. We found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because medicines were not always managed safely. We also found that some staff had not received fire training and some staff had never participated in a fire drill. Accidents and incidents were not recorded correctly, and the accident book was not clear and concise regarding accidents and the management of injuries.

People were not protected against the risk of harm and action was not taken to prevent the potential for or actual harm. Some people had the wrong size mattresses on their beds causing potential risk of entrapment between the mattress and the bed sides. During our previous inspection people who were receiving end of life care did not always have their pain managed effectively.

We also found a breach of Regulation 18 of the Social Care Act 2008 (Regulated Activities) Regulations 2014. Agency staff had not received appropriate induction to the home and we could not see evidence of training they had completed. Staffing levels could not meet the needs of people. Staff were rushed and had little time to positively interact with people. The provider submitted an action plan to ensure improvements were made.

We found during this inspection improvements had been made. Agency staff had received an induction and staff had received fire training. We could see evidence of agency staff training details and induction procedures when they first worked at the service. Agency staff we spoke with told us; "I had one day induction where I was shown the fire exits and layout of the building and worked with a senior member of the team. But when I came back the next day, I was expected to 'get on with it.' I found this challenging." However, another agency member of staff told us, they felt part of the team and felt the one day induction was sufficient as they 'picked it up as they went along'.

Our previous inspection found staffing levels were not able to meet the needs of the people living in the home. We found during this inspection improvements had been made in relation to deployment of staff. Staffing levels were able to meet the needs of the people in the home. Staff were able to spend time with people in an unhurried manner and were able to initiate conversations with people about their day.

The provider had made improvements in relation to the recording of accidents and incidents and managing people's end of life care. We found accidents and incidents were recorded appropriately. People receiving end of life care had adequate support and management of their symptoms with specialist healthcare professionals.
Anticipatory medicines were available if people required them. Anticipatory medicines are specific medicines designed to enable prompt symptom relief at whatever time a person develops distressing symptoms. People had the correct mattresses on their bed to avoid potential entrapment.

During our previous inspection we had some concerns around the stair gate at the top of the main staircase.

We found that the service had reviewed the risk assessment concerning the stair gate at the top of the main staircase. We spoke to the regional manager about this and they said the service needed to balance the safety of people with maintaining their independence and felt the balance was right. We noted that no one had fallen down the main staircase but we were aware someone had fallen down another small staircase within the home. The service had taken measures to reduce the risk of people falling on the small staircase.

We looked at people's risk assessments regarding the stairs. One person had a risk assessment that documented the person was at risk of falling down the stairs and staff should monitor them. Another person's risk assessment said 'at risk of falling down the stairs' and information was for staff to ensure the person was accompanied when they use the staircase. We discussed this with the regional manager in relation to how staff document they assist and accompany people when they use the stairs. The regional manager told us it would be difficult for staff to document each time a person uses the stairs. However, we were aware daily notes were completed which ensured people's daily activities were recorded.

We discussed other options regarding the stairs and the regional manager told us they did not want to take people's independence away by blocking the stair case off.
We recommend procedures around the gate at the top of the main staircase are kept under review.

We found during this inspection the service had ensured medicines were managed effectively. We saw MAR charts were not always completed to show what medicines people had received. For example, we noted several missing signatures where staff had not signed for the medicines they had given to people. However, the provider who was investigating the shortfalls had identified this through their audits. Staff had documented on the medicine chart that they were unable to 'find' a person's prescribed cream for two days. This was discussed with the provider who provided additional evidence following the inspection from the pharmacist and GP to provide us with assurance that people's medicines were being managed effectively.

The service followed safe recruitment procedures. Interview records demonstrated prospective staff members' employment histories were reviewed as part of the recruitment process. Disclosure and Barring Service checks (DBS) were completed before staff were appointed to positions within the home. The DBS enables organisations to make safer recruitment decisions by identifying candidates who may be unsuitable for certain work, especially that involve children or vulnerable adults.

People were protected against abuse and neglect. Staff we spoke with told us they had completed training in safeguarding and would not hesitate to report any concerns. Safeguarding information was displayed within the home along with contact details if people were concerned about abuse.

Good

Is the service effective?

Our findings

At our previous inspection in December 2015, we rated this key question as 'requires improvement'. We found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff were not properly supported and monitored and had not received appropriate supervision. We also found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people and their representatives had not given consent to the care and support provided.
We asked the provider to submit an action plan to ensure improvements could be made.

We found that the provider was now meeting this regulation. We saw evidence that consent was sought and where required, mental capacity assessments were carried out to determine people's capacity. Any restrictions placed on them were in their best interest with the relevant professionals involved.

We saw that improvements had been made in relation to staff supervisions. Staff supervisions took place, however this was not always on a regular basis. The deputy manager we spoke with told us supervisions took place every six weeks. However, we could not see evidence that this was accurate. Staff we spoke with told us they had supervisions and they felt supported by the management. One member of staff told us, "There has been a lot of change. I now have regular supervisions and the management are more supportive. I am happy now".

We could see evidence of staff training details and induction procedures when they first worked at the service. Staff received mandatory training in areas such as manual handling, safeguarding, infection control, fire awareness. Additional training in subjects such as, dementia was available to ensure staff met the needs of people using the service.

We observed a 'take ten minutes' meeting which was facilitated by the operations manager. The purpose of this meeting was to get staff to think about how their morning shift had gone and to reflect on this. The operations manager asked staff to think about a word that summed up their shift. This was then shared with the group as a whole. This demonstrated the service valued staff and acknowledged their contribution to the home.

Staff received training that enabled them to meet people's needs effectively. Relatives we spoke with told us, "They look after [our family member] well; this has been the happiest four years of our lives". Other relatives told us that even though their family member was bedbound, the staff were always patient and explained everything they were doing. The relative told us that staff often 'pop in' and sit with their relative to give them some company.

Relatives spoke positively about the service. One relative told us, "I am really happy with the care provided to [my family member]. I feel they are safe here." Another family member told us, "This place is my life; I am part of the furniture here. I have nothing but praise. They seem to have sorted themselves out with just one agency". Other comments included, "It's a great improvement from a few months ago."

The Mental Capacity Act 2005 provides a legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The Act requires 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 interest and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when it 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). There had been several applications made to the local authority.

People's consent to care and treatment was sought in line with legislation. The members of staff we spoke with demonstrated a good understanding of the requirements of the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). Comments included, "It is how they understand what is happening in their care" and "We explain what we are doing all the time".

People were supported during meal times. We saw some people had their meal in the dining room where tables were set with tablecloths and cutlery. Other people had their meal in the lounge area watching television. One member of staff said, "We leave them in there (the lounge) as they disturb the others and pull the tablecloth off, but we keep our eye on them". The chef told us, "I am aware of the nutritional needs of older people and I know who has diabetic meals and who has difficulty swallowing". One relative told us, "[Mother] is on a specific diet; everyone knows about it". We saw that snacks and jugs of drinks were available in the hallway for people to help themselves. Where people required assistance with their meal staff were available to offer support.

When necessary, health and social care professionals were involved in people's care and support needs. This included district nurses and the mental health team. We spoke with the visiting GP during our visit; they told us the home had good links with the palliative care team for support and advice.

People had access to health and social care professionals. Records demonstrated the service had worked effectively with other health and social care services to ensure people's needs were met. Records confirmed people had access to a GP dentist and optician and could attend appointments when required. When we spoke with the GP during our inspection they spoke positively about the service.

The service completed nutritional screening, regular weighing, referral to dietitian/speech and language therapist where required.

Good

Is the service caring?

Our findings

At our previous inspection in December 2015, we rated this key question as 'requires improvement'. We found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people did not receive adequate support towards the end of their life to enable them to have a dignified pain free death. We asked the provider to submit an action plan to ensure improvements could be made.

The provider was now meeting this requirement. We found during this inspection people were supported by palliative care specialists when required. The visiting GP told us, "They don't phone me unnecessarily. I visit every Tuesday. There is good support from the palliative team. This is a good loving and caring home." We saw that when people were frail and receiving end of life support they were comfortable and had specific anticipatory medicines in the home to be used if their health deteriorated further.

We observed how staff interacted with people to see if they were actively involved and given choice and independence. For example, we saw that one person enjoyed their own company and spent time in the conservatory away from the 'busy' part of the home. Staff told us this was the person's preferred place to spend their day. We reviewed individual files and found information that people and their relatives were actively involved in care reviews. One visiting relative told us, "I am involved in care plan reviews and have regular meetings". Another relative told us how relieved they were to find this home where their family member was treated with care and dignity.

Throughout our visit staff were observed addressing people by their preferred name and interacted with them in a supportive manner. Staff spoke with people in an unhurried manner and spent time chatting about the day and admiring their newly painted nails which had just been completed with the activity coordinator. We saw that a visiting relative was made to feel welcome and they told us they had no concerns about the home and said that interaction was very good.

People looked well-groomed and cared for and were able to personalise their rooms with items brought in from their home. Relatives could visit without any restrictions. The home had a 'daily sparkle'. This was printed information for people to read that had stories about famous film stars from the past that encouraged conversations with people.

Staff built relationships with people. For example, the service had a strong person centred culture, people's life histories and interests were included in the pre admission assessment. In addition, the service incorporated a key worker system. A key worker system is when a person receiving care has a specific member of staff allocated to them. The member of staff ensures particular specified needs are met. If any issues or concerns are raised by the person or their family the key worker would be the first point of contact.

People had care plans in place for end of life preferences that enabled them to be actively involved in making decisions about their care, treatment and support. We saw people or their families had discussions around their end of life wishes. In addition do no attempt resuscitation (DNAR) orders were in place in

people's files, after this had been discussed with the GP and families.

Good

Is the service responsive?

Our findings

At our previous inspection in December 2015, we rated this key question 'requires improvement'. We found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not supported to take part in social activities.
We asked the provider to submit an action plan to ensure improvements could be made.

We found during this inspection the provider had an activity programme in place. The provider had employed an activity coordinator to support people to take part in social events. The home had a 'daily sparkle'. This was printed information for people to read that had stories about famous film stars from the past that encouraged conversations with people. We observed the 'singing vicar' on the first day of our inspection. People joined in with the singing and appeared to enjoy the entertainment. The activity coordinator told us, "It is very important to note those who remain in their bed. I do lots of one-to-ones". The activity coordinator was involved in the 'Ladder to the Moon' training which offered creative activity services. One relative told us their family member was now too frail to get out of bed and staff would often sit with them and talk to them to offer them some company.

People or their relatives were involved in developing their care, support and treatment plans. Care plans were personalised and detailed daily routines specific for each person. Staff were able to explain how people preferred to be cared for. For example, staff could tell us about people who were frail and whose health was deteriorating. Staff told us about people who required positional changes to avoid pressure damage and who had their food monitored due to weight loss. However, one agency member of staff told us that one person receiving end of life care was able to eat and drink. We noted the report from the visiting GP about the person dated 22 November 2016. The advice from the GP was to only give stage three thickened fluids slowly. We discussed this with the regional manager during our feedback. They told us they would 'look into this'.

Relatives we spoke with told us people had care plan reviews. One relative said, "I have regular meetings and reviews of the care plan". We asked family members if they knew how to make a complaint. One relative said, "How to make a complaint was in all the [documents] I got when we arrived. I always attend the residents' and family meetings". There was a range of ways people and their families could say how they felt about the service such as satisfaction surveys and questionnaires.

The service had received one complaint in the last 12 months we saw evidence this had been investigated and following the investigation had been closed.

Good

Is the service well-led?

Our findings

At our previous inspection in December 2015, we rated this key question 'requires improvement'. We found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because quality monitoring systems in place were not effective in assessing, monitoring and improving the quality and safety of services provided. Staff had not monitored people's changing needs. Where accidents and incidents had occurred there was repeatedly no action plan to address this. Health and safety audits undertaken did not identify safety risks. People had gaps between their mattress and the bed frame. The stair gate at the top of the main stair case was constantly left open by staff. We asked the provider to submit an action plan to ensure improvements could be made.

We found during this inspection quality monitoring systems identified people's changing needs. Accidents and incidents were monitored to ensure action plans were in place when required. People had appropriate mattresses that did not pose a risk of entrapment.

We reviewed a range of quality audits used by the service. These included care plan audits, medicine audits and maintenance of the home. We found that the audits had improved but sometimes did not identify shortfalls. For example, we found a radiator cover loose and found a person pulling the cover away from the wall and then pushing it back. We also found a loose piece of metal protruding from the bottom of a bench at the top of the stairs. We pointed these out to the maintenance person who escorted us around the home. We were told these would be fixed. Medicine audits were far more effective. However, they had not identified that some medicines had not always been available for people.

The service had been without a registered manager for over 28 days. The deputy manager was responsible for the management of the home with support from the regional manager. The regional manager had introduced a meeting for staff to discuss the way their shift had gone. Staff told us this was very useful and made them feel an important part of the service. A comment from an agency member of staff was, "I feel part of the team they include me". This demonstrated the service promoted their values within the service and the staff team.

We asked relatives and staff whether they felt the service was well-led. Relatives told us they felt, 'things had improved' whilst staff told us, "The morning meetings are good. There is a nice atmosphere" and "I feel supported and I am happy".

We were provided with meeting minutes from staff meetings; one held in April 2016 and July 2016.

However, we could not see evidence of night staff meetings taking place other than one held in October 2013, although we were told that they had taken place. The meetings discussed a range of topics, from reminding staff to read the 'take ten minutes' meeting notes which were displayed in the staff room, to requesting staff to read the policy file and sign to confirm they had read and understood the policy. They also praised the staff for good practice as well as bringing up issues for discussion.

The provider had a legal duty to inform us about certain changes or events that occur within the service. Statutory notifications had been sent to us as required by relevant regulations. Examples of notifications sent included the absence of the registered manager for a period of time.

The service enabled and encouraged open communication with people, those that mattered to them and staff. This was demonstrated through satisfaction surveys and questionnaires. The 'take ten minutes' meetings with staff ensured staff felt included and empowered.

The service had a clear vision and set of values that were understood and promoted by staff. Staff we spoke with knew how to raise concerns and told us they felt able to do so. Feedback given to staff was constructive and motivating.