Key inspection report

Care homes for adults (18-65 years)

Name:	Woodtown House Nursing Home
Address:	Alverdiscott Road Woodtown House East-the-water Bideford Devon EX39 4PP

The quality rating for this care home is:	one star adequate service

A quality rating is our assessment of how well a care home is meeting the needs of the people who use it. We give a quality rating following a full review of the service. We call this full review a 'key' inspection.

Lead inspector:	**Date:**							
Susan Taylor	0	3	0	2	2	0	1	0

This is a review of quality of outcomes that people experience in this care home. We believe high quality care should

- Be safe
- Have the right outcomes, including clinical outcomes
- Be a good experience for the people that use it
- Help prevent illness, and promote healthy, independent living
- Be available to those who need it when they need it.

The first part of the review gives the overall quality rating for the care home:

- 3 stars - excellent
- 2 stars - good
- 1 star - adequate
- 0 star - poor

There is also a bar chart that gives a quick way of seeing the quality of care that the home provides under key areas that matter to people.

There is a summary of what we think this service does well, what they have improved on and, where it applies, what they need to do better. We use the national minimum standards to describe the outcomes that people should experience. National minimum standards are written by the Department of Health for each type of care service.

After the summary there is more detail about our findings. The following table explains what you will see under each outcome area.

Outcome area (for example Choice of home)

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

This box tells you the outcomes that we will always inspect against when we do a key inspection.

This box tells you any additional outcomes that we may inspect against when we do a key inspection.

This is what people staying in this care home experience:

Judgement:

This box tells you our opinion of what we have looked at in this outcome area. We will say whether it is excellent, good, adequate or poor.

Evidence:

This box describes the information we used to come to our judgement.

We review the quality of the service against outcomes from the National Minimum Standards (NMS). Those standards are written by the Department of Health for each type of care service.

Copies of the National Minimum Standards – Care Homes for Adults (18-65 years) can be found at www.dh.gov.uk or bought from The Stationery Office (TSO) PO Box 29, St Crispins, Duke Street, Norwich, NR3 1GN. Tel: 0870 600 5522. Online ordering from the Stationery Office is also available: www.tso.co.uk/bookshop

The mission of the Care Quality Commission is to make care better for people by:

- Regulating health and adult social care services to ensure quality and safety standards, drive improvement and stamp out bad practice
- Protecting the rights of people who use services, particularly the most vulnerable and those detained under the Mental Health Act 1983
- Providing accessible, trustworthy information on the quality of care and services so people can make better decisions about their care and so that commissioners and providers of services can improve services.
- Providing independent public accountability on how commissioners and providers of services are improving the quality of care and providing value for money.

Reader Information

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Information about the care home

Name of care home:	Woodtown House Nursing Home
Address:	Alverdiscott Road Woodtown House East-the-water Bideford Devon EX39 4PP
Telephone number:	01237470889
Fax number:	01237472634
Email address:	info@deepdenecare.org
Provider web address:	www.deepdenecare.org

Name of registered provider(s):	Deepdene Care Ltd
Type of registration:	care home
Number of places registered:	28

Conditions of registration:		
Category(ies) :	Number of places (if applicable): Under 65	Over 65
mental disorder, excluding learning disability or dementia	28	0

Additional conditions:

The maximum number of service users who can be accommodated is 28.

The registered person may provide the following category of service only: Care home with nursing- Code N to service users of either gender whose primary care needs on admission to the home are within the following category: Mental disorder, excluding learning disability or dementia- Code MD

Date of last inspection								

Brief description of the care home

Woodtown House is registered to provide 24-hour nursing care to 28 service users with a past or present mental illness. The home is a large detached Georgian house standing in it's own grounds. Although in a rural setting the home is within a few minutes drive of Bideford and Torrington. A 7 seater people carrier is provided for transport. There is a large garden with plenty of seating and areas of cultivation for vegetables and plants. There are bedrooms on the ground and first floors. Seven have ensuite facilities and are suitable for disabled people. There is no lift. There is a

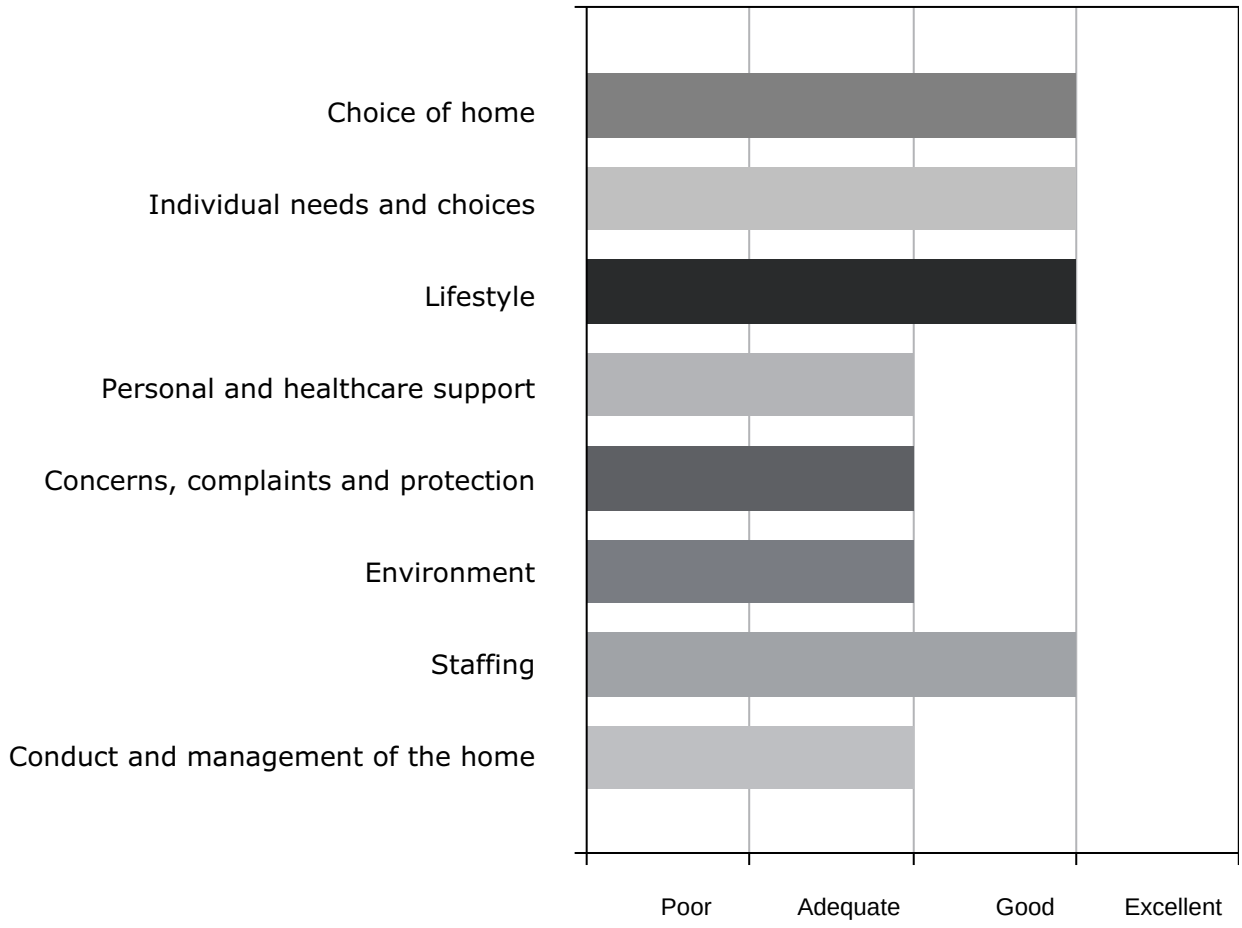
Brief description of the care home
rehabilitation flat situated on the second floor, for service users who are working towards greater independence. Woodtown House is a non smoking environment. However, people are able to smoke in the grounds and an external smoking shelter. In February 2010, the fees for the home ranged between £477.41 - £1645 per week. Additional charges are made for hairdressing, toiletries and newspapers dependent upon individual requirements.

Summary

This is an overview of what we found during the inspection.

The quality rating for this care home is:	one star adequate service

Our judgement for each outcome:



How we did our inspection:

The quality rating for this service is 1 stars. This means the people who use this service experience ADEQUATE quality outcomes.

Two inspectors were at the home with people for 21 hours. The purpose for the inspection was to look at key standards covering: choice of home; individual needs and choices; lifestyle; personal and healthcare support; concerns, complaints and protection; environment; staffing and conduct and management of the home.

We have been involved in safeguarding procedures, which highlighted concerns about the specific care of people that were living or had lived in the home. As a result of this, named people were reviewed. We did a random inspection on 30th November 2009. A report of this visit has been published. We brought this key inspection forward to determine whether people's needs are being met and to decide whether the home is being run effectively. We specifically looked at the care of people that have physical

and mental health disabilities. The provider is involved in the safeguarding process and has been working in partnership with professionals visiting the home to improve the care outcomes for people.

We looked closely at the care, services and accommodation offered to 4 people living at Woodtown House, all of whom are physically disabled in addition to having mental health needs. This is called case tracking and helps us to make a judgement about the standard of care, and helps us to understand the experiences of people who live at Woodtown House. We looked at the care and attention given by staff to these people and we looked at their assessments and at their care planning records. We looked at the environment in relation to their needs and how their health and personal care needs are met.

We looked at other records, policies and procedures in the office. We met another 9 people that live at Woodtown House and observed how staff looked after them. We met 8 staff and the manager. We sent surveys to 10 people living in the home and received 6 back. We also sent surveys to 10 staff and received 6 back. We have had reports from health and social care professionals as part of asafeguarding process. The comments from people, the results of surveys and our observations are in the report.

In February 2010, the fees ranged between £477.41 and £1645 per week for nursing and personal care. Additional charges are made for chiropody, hairdressing, newspapers and toiletries and these vary. The provider is moving towards all inclusive fees, which would include most of these items. This is negotiated during the assessment process.

People funded through the Local Authority have a financial assessment carried out in accordance with Fair Access to Care Services procedures. Local Authority or Primary Care Trust charges are determined by individual need and circumstances. General information about fees and fair terms of contracts can be accessed from the Office of Fair Trading web site at www.oft.gov.uk.

What the care home does well:

People using the service say that Woodtown House is a "family home with a country feel" and "a fantastic place" place to live. People are given a lot of information enabling them to decide whether it is the right home for them. The team get know a person's needs and agree a plan with them as to how they will be met.

The range of activities is increasing, and people tell us that they have much more choice about this. People are encouraged to take part in activities, outings and events which they have an interest in. For example, some people tell us they are enjoying going out shopping to buy their own clothes.

People living in the home tell us that they have a good choice of meal, which are filling and "lovely". Events are held like barbecues and parties that help people to keep in touch with their families and friends. Similarly, people tell us that a holiday is being planned.

There are policies and procedures that protect people. People know how to make complaints and say that they can voice their concerns and feel that staff listens to them.

Checks are done before staff are allowed to work with the people that live at the home. Staff is encouraged to do training so that they all keep up to date and understand how to care for people that live at Woodtown House.

The provider is clear about how they can improve the quality of life for people at the home.

What has improved since the last inspection?

People are better protected from the risk of infection. All of the staff are aware of current best practice and put this into effect.

People are better protected from the risk of fire. Fire drills, practices and training are done at suitable intervals with staff and people living in the home.

Pre-employment checks have been obtained before new staff is allowed to work in the home and this ensures that people living there are protected.

People who are at risk of falls and choking have been assessed and steps taken, where possible, to minimise these.

The air quality for people living in bedrooms off the main lounge has been improved by the introduction of a no smoke zone in the home. Some parts of the home have been updated with new furniture and fittings, so people live in a more comfortable home.

People are given more frequent opportunities to comment about the quality of their life, accommodation and service.

The skills, experience and knowledge of staff has been reviewed and changes made to ensure that it is consistent with the diverse needs that people have that live at

Woodtown House.

The Commission is being notified about nearly all serious incidents.

What they could do better:

We have made legal requirements about the following issues:

Risk management systems are inconsistently applied which means that some aspects of the health and welfare of people that are physically disabled has not been adequately maintained.

Whilst good practice is being followed in working towards a more personalised approach for people regarding their social activities, some institutional practices within the home (such as locked doors and prepared drinks) have the potential to create a controlling atmosphere and devalue individual rights of choice and freedom of movement.

People must be confident that that their medicines are effective by having them stored at the correct temperature.

Communication processes within the home are not sufficiently robust to ensure that consistent messages are given with regard to personal care needs of people living in the home.

Safeguarding procedures are not consistently followed and therefore may impact on the effectiveness of managing known risks for people.

Recording does not always reflect the practice or decisions described by staff. Therefore, there is the potential for people to receive inconsistent care as a result of this.

We have made recommendations about the following issues:

People should have access to the terms and conditions of their residence at Woodtown House, so that it is clear what level of service they should expect.

People that need assistance to move and transfer should be confident that all of the staff have had up to date training and are competent to do this.

The manager should be supported to apply for registration so that they do not operate outside of the law. This will ensure that people living there are confident that the manager has appropriate qualifications, experience and competency to run the home.

If you want to know what action the person responsible for this care home is taking following this report, you can contact them using the details on page 4.

The report of this inspection is available from our website www.cqc.org.uk.

You can get printed copies from enquiries@cqc.org.uk or by telephoning our

order line 0870 240 7535.

Details of our findings

Contents

Choice of home

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People are confident that the care home can support them. This is because there is an accurate assessment of their needs that they, or people close to them, have been involved in. This tells the home all about them, what they hope for and want to achieve, and the support they need.
People can decide whether the care home can meet their support and accommodation needs. This is because they, and people close to them, can visit the home and get full, clear, accurate and up to date information. If they decide to stay in the home they know about their rights and responsibilities because there is an easy to understand contract or statement of terms and conditions between the person and the care home that includes how much they will pay and what the home provides for the money.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People living in the home are generally confident that their needs are known. Recent changes to the staffing has ensured that the team have the right skills and experience, which is beginning to benefit people.

Evidence:

The home has a Statement of Purpose and information that the provider sent to us verified that a brochure is given to all people which sets out what the service will provide and other information to help people decide whether the home is right for them. Six people responding in a survey verified that the home provided sufficient information for them to make decisions about whether to live at the home or not. We saw that some people had a copy of this in their room.

We looked at 5 care files to establish whether the care delivered was based on detailed assessment of people's needs. The funding authority assessment and care plan are obtained together with any health care assessments and information about what medication the individual is taking.

Evidence:

The manager told us that 2 staff usually go to visit a prospective resident before the person is invited to visit. One of these staff is the clinical lead and a registered nurse. We case tracked a person's experiences leading up to and moving into the home. The person had been able visit the home several times before deciding whether to move in. Records highlighted that the person 'enjoyed' the visits. The in house assessment contained detailed information about the individual's physical, mental, psychological and social needs. Parts of the assessment demonstrated that staff have some understanding of person centred assessment and planning, with comments like 'XXX is a gemini and her favourite perfume is topaz' and 'she is very artistic and likes to paint'. Additionally, the assessment was risk based and looked at an individual's behaviour, physical health mental health and safety. This is discussed in more detail under the section entitled 'Personal and healthcare support'.

We were unable to see individual contracts for people that we case tracked. We were told these are held at the Head Office in London. No copies of these were available and therefore people did not have access to this information.

Individual needs and choices

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People's needs and goals are met. The home has a plan of care that the person, or someone close to them, has been involved in making. People are able to make decisions about their life, including their finances, with support if they need it. This is because the staff promote their rights and choices. People are supported to take risks to enable them to stay independent. This is because the staff have appropriate information on which to base decisions.
People are asked about, and are involved in, all aspects of life in the home. This is because the manager and staff offer them opportunities to participate in the day to day running of the home and enable them to influence key decisions. People are confident that the home handles information about them appropriately. This is because the home has clear policies and procedures that staff follow.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People are involved in planning their care and quality of life at Woodtown House. Poor recording may impact the consistency of care and support people experience.

Evidence:

We looked at 4 care plans in detail and met the people that they referred to and spoke with the people caring for them. We also observed how care staff interacted with people living at the home to see if they followed the guidance in people's care plans. We also looked at specific areas in other care plans to gain a broader picture of how guidance and care is recorded. When we last visited staff confirmed that they had access to care plans, and we saw staff referring to care plans during this inspection, and taking relevant information with them when they accompanied someone living at the home to a meeting with a psychiatrist.

When we spoke with staff, they recognised the individuality of the people living at the home and spoke about them with affection and respect. Staff that we spoke to showed a capacity to put themselves into the world of the people living at the home. For

Evidence:

example, they recognised that one person views themselves as a landowner with agricultural responsibilities. This understanding was based on information received in 2008 from a family member and from interpreting the person's actions and interests. We observed the individual talking about their concerns with staff, and saw staff reassuring them. However, their care plan did not contain this valuable information, which would help all staff provide a consistent approach and understanding of the person's sense of responsibility and their resulting actions. There are times when poor recording does not reflect the practice or decisions by staff.

Each care plan that we looked at had monthly reviews in place but the quality of their completion varied. Currently they do not provide a robust overview of people's care and do not confirm that all aspects of a person's care have been considered and the risks measured. For example, we saw that one person we were case tracking had diabetes, in their care plan it stated that this would be partly managed by encouraging a healthy diet. We looked at two of the most recent monthly reviews but there was no reference to this area of care so there was no indication that the risk to their health had been monitored.

Conversely, the care plan of a person who was known to be at risk of choking had been reviewed and the plan updated to reflect increased risks following a medical emergency that required hospitalisation of the individual. The plan was detailed and provided clear guidance for staff to follow. For example, we observed this being followed at lunchtime as staff discreetly monitored the person whilst they were eating. Staff told us that they had prompted the person to make certain meal choices that the individual would be able to cope with better. The person was quite restless and becoming agressive towards other people. This situation was calmly diffused and the person returned to their table to concentrate on eating their meal. Therefore, the potential for choking was reduced by the actions of staff who were following the plan.

People are well consulted about changes in the home. We were told that a "meeting is held every 2 weeks", and one person "types up the minutes". We were told that at the most recent meeting people had been informed about "management changes". For example, people knew that generally trained nurses were now working between 9-6pm and are able to provide extra advice and support about physical health needs.

The home has a policy and procedure for the management of petty cash. Monthly audits had taken place of the all the financial management systems. All of the people living in the home are being encouraged to open their own savings/bank accounts. The manager told us that there are named key holders for the safe. We looked at records for 4 people. Balances tallied across records. People living in the home verified

Evidence:

that the petty cash was accessible to them. Receipts for purchases had been obtained and balances tallied with records kept.

We were told of a very recent incident when somebody living at the home had left in the early hours of the morning and had been brought home by the police, which was when staff realised they were missing. Reports indicated that none of the staff on duty had completed the person's two hourly check due at 6.30am, which meant that they were not missed. During the inspection, the manager told us how they planned to address this matter with staff, and told us the day after the inspection that they had now put in place a two hourly observation list which must be signed by staff to confirm completion of this task.

We were told that the above person and another vulnerable person living at the home were now on hourly observations, we saw records to show this was taking place but one staff did not have this information recorded on their handover sheet, and although they could tell us the names of both people, there was only one name they were certain of. This example and the one above indicate that the systems to monitor people's safety are not sufficiently robust. Since the inspection, the provider has told us that these shortfalls have been addressed.

We looked at the home's policy for missing person's which stated that a form must be completed when people move to the home. We were told that only two people were at risk of absconding and that forms had only been completed for these two people. We looked in one file and saw the form in place but staff told us that the other had not been returned to the file after an incident the day before. Neither person had a log of incidents recorded, although the company's policy stated this should be in place. This shows a lack of consistency in following the home's policy.

Lifestyle

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

Each person is treated as an individual and the care home is responsive to his or her race, culture, religion, age, disability, gender and sexual orientation. They can take part in activities that are appropriate to their age and culture and are part of their local community. The care home supports people to follow personal interests and activities. People are able to keep in touch with family, friends and representatives and the home supports them to have appropriate personal, family and sexual relationships. People are as independent as they can be, lead their chosen lifestyle and have the opportunity to make the most of their abilities. Their dignity and rights are respected in their daily life. People have healthy, well-presented meals and snacks, at a time and place to suit them.
People have opportunities to develop their social, emotional, communication and independent living skills. This is because the staff support their personal development. People choose and participate in suitable leisure activities.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People have better access to hobbies, outings and activities of their choice.

Evidence:

We saw from the minutes of a staff meeting that staff were being encouraged to ensure that activities should take place four days a week in conjunction with shopping trips. We visited a kitchen that people living at the home have supported access to, although the manager told us that the design is not enabling for people using wheelchairs and explained how this was being addressed. We heard that two people had made use of the kitchen and that it had been a beneficial experience. A list was on the kitchen door so that people could put themselves forward to use the kitchen. We heard that mug painting had taken place and we saw from minutes that more work was needed to make this more successful, and that gardening activities are planned.

Evidence:

Shopping is a regular feature of most people's daily routine, and we heard people choosing either for carers to shop on their behalf or to go out on an individual basis. For example, an individual was being supported to go out to buy clothes, and we heard the manager ensuring that they had access to enough money.

We looked at 3 files to see how people were supported to access the local community and take part in activities that interest them. Two files showed that the people were reluctant to take part in group activities, although one person regularly attended residents' meetings, and this was discussed with them in their monthly reviews and different options explored. The third person's records showed that they took an active part in both one to one sessions, and group activities. As well as accessing the local community through a holiday and shopping trips.

We saw that one person has a strong religious belief but there was little reference to how or if they needed support with being able to practice their faith in their care plan. We were told that they had received visitors from their faith and this was recorded in their monthly review.

At the last inspection, we reported that we observed some institutional practices during the meal, which negate the promotion of independence and individual choice. For example, people had to ask for condiments rather than these being on the table and we saw people helping themselves to tea and coffee from a heat retaining flask with milk already in it. This situation has not changed and should be reviewed so that people are encouraged to be more independent. Therefore we have repeated a requirement about this.

We asked a staff member how people's dietary needs would be monitored, they referred us to the records kept in the kitchen. We looked at the records of meals over seven days, which were incomplete, and staff said they were not accurate reflection of what meals people had eaten. For example, 2 people who are diabetic are recorded on separate days not to have eaten all day. There was only one occasion that the charts had been signed off by a senior staff member and this was despite the record being incomplete. There was also a lack of consistency in how the plans were used, so sometimes choice was recorded, sometimes it wasn't. We asked how temporary staff working in the kitchen (as happened on the day of the inspection) would know who was diabetic, we were told by different staff members that a list had been put up in the kitchen but this could not be found. We asked the person in the kitchen, and they could not name all of the people with diabetes, which meant that people may not be given appropriate meals.

Evidence:

We asked if there was anyone having their food intake monitored because of concerns for their health. We were told there was nobody at present but we were shown retrospective sheets, although they were not sequential as a sheet seemed to be missing, and saw that these had ceased. We checked the person's care file and we saw that they had been reviewed and ceased as a result of the review. Following this inspection, the provider informed us that the shortfalls in recording and communication in respect of monitoring the nutrition of this person were addressed immediately.

Personal and healthcare support

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People receive personal support from staff in the way they prefer and want. Their physical and emotional health needs are met because the home has procedures in place that staff follow. If people take medicine, they manage it themselves if they can. If they cannot manage their medicine, the care home supports them with it in a safe way.

If people are approaching the end of their life, the care home will respect their choices and help them to feel comfortable and secure. They, and people close to them, are reassured that their death will be handled with sensitivity, dignity and respect, and take account of their spiritual and cultural wishes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Risk management systems show signs of improvement, however poor recording may impact the consistency of care and support people experience.

Evidence:

Following a safeguarding meeting in November 2009, we asked the provider to ensure that a risk assessment was undertaken of all people with a physical disability with regards to their tissue viability status and for appropriate action to be taken. We checked this at this inspection.

We tracked the care of a person with physical disability who had been assessed as being as risk of tissue breakdown. We looked at the individual's care file and nursing staff had recently assessed the person using the 'Waterlow' tool to determine the level of risk of potential pressure damage the person might experience. We saw two different documents, which had contradictory scores. We spoke to 2 registered nurses to verify what their understanding was in relation to risk management of the individual we were casetracking. Both staff told us that they were unsure, which Waterlow score was being used. We asked one of the nurses to re-assess the person and they confirmed that the individual was at 'very high risk' (20+) of pressure damage due to

Evidence:

their poor health. Additionally, we read in the person's daily records that most nights they were sleeping in a reclining chair, which increases the level of risks for that individual. Measures had been not been put in place to prevent the risk of pressure damage occuring. Best practice guidance recommends that individual's in this position should have suitable equipment such as a pressure relieving cushion and a zero pressure mattress on their bed to minimise the risks. We asked the manager to contact the tissue viability nurse specialist for further advice and we have received confirmation that this was done the following day. Additionally, the provider told us that a pressure relieving mattress and seat cushion had been obtained and was being used by the individual.

We saw that a person who had diabetes had no reference in their care plan to how their foot care would be managed, which we would expect because this is good diabetic practice. We asked how their foot care was managed, a file was found that showed they had regular access to a chiropodist. However, there was no reference to this in their care plan or their reviews so there was no indication that the risk to their health had been monitored. The provider has since informed us that each person has a treatment card, which records the treatment they have had to date, the frequency of visits and next appointments.

We asked how people's weight was monitored, there is a section for this to be recorded on the monthly review form. We saw some sections had been left blank. We saw that for one person, they had not been weighed since September 09. This information was only found with the help of staff by looking through different sections in the care plan, and looking at a separate sheet with weights for approximately seven people carried out in December. We saw that records do not clearly state that people have chosen not to be weighed, although staff said this was often the case, and there was no method in place to replace using scales i.e. visual observation or other recognised methods.

Care files showed us that people have access to health services, such as the dentist or being given a flu vaccination. We met a healthcare professional who was visiting a person at the home. They told us that there is "excellent communication in the home" about the needs of this person. Additionally, they told us that "referrals [to the Community nursing team] are appropriate and timely".

We saw how somebody's health had been monitored by the home and could see that decisions were recorded. For example, the monitoring a person's swallowing reflex after a change in their health. We also saw records of how the person had been consulted about their treatment and their decision respected.

Evidence:

During our inspection, we saw staff negotiating with people about their behaviour and also being open about concerns or risks. Staff were non judgemental in their approach to people's mental health and showed compassion regarding their emotional well-being. For example, we case tracked an individual who has a history of destructive behaviour and who also had assessed risks in respect of safety. A behavioural plan had been developed to help the individual control their cigarette intake, which also maintained their safety. We saw evidence in the individual's care file demonstrating that these limits had been discussed at length with the person. We observed this being put into effect with the individual in a positive way that respected the person's dignity.

We also observed that staff deal with challenging behaviour in a positive way. One of the people we case tracked was quite restless and becoming agressive towards other people. This situation was calmly diffused and the person returned to their table to concentrate on eating their meal. Records of reviews also showed that over the course of a few months, the person had become calmer and was feeling more in control of their life at Woodtown House. Other people remarked that the person "seems happier" and told us the individual is "talking more".

Similarly, another person we case tracked told us that they had a bipolar disorder. We saw in their care records that their mental health had improved in some ways, in that the individual was 'more sociable' and 'less isolated'. The person had regular 1:1 sessions with the key worker and when we spoke to them they told us that Woodtown House is "a fantastic place". Staff had recognised that this person's cognitive abilities were declining and had arranged for screening to be done in conjunction with the individual's GP. Therefore, people's mental health needs are well met.

Changes have been made to where medications are stored and dispensed from. These are now kept in a larger room, which has a solid door with a small hatch in it. People due medicines are encouraged to come up to the door to be given their tablets. We observed that this is another example of institutional practice, which is not person centred and have made a requirement about this under section 3. Additionally, the temperature of the room was excessively hot due to there being hot water pipes running down the wall of the room. Some medicines need to be kept at room temperature, around 18 degrees centigrade. However, the temperature of the room far exceeded this. Therefore, the provider cannot be sure that medicines are being stored within safe limits which could result in people being given defective medicines.

We observed a nurse administering medication in the evening and this was done

Evidence:

safely. A local surgery dispenses medicines for people living at the home. One of the trained staff is responsible for stock taking. We looked at records of ordered drugs and a register of controlled drugs, although no one was currently prescribed this type of medication. The system was easy to audit. Medication charts had been completed appropriately. Medication had been given as prescribed. People living in the home felt that medicines were handled well and we observed an individual for example asking for, and then being given pain relief promptly.

Since the random inspection on 30th November 2009, we have seen that some steps have been taken to assess risks in relation to the management of people's health. However, the information gathered has not been used effectively or consistently to demonstrate that the risks for people are being minimised. Staff told us that a 2 day course had been arranged in mid February 2010 for all staff covering risk management, and would include the assessment and management of people's tissue viability. Therefore, we have repeated and extended the timescale of 2 requirements so that the provider is able to have a robust risk management system in place.

Concerns, complaints and protection

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

If people have concerns with their care, they or people close to them, know how to complain. Their concern is looked into and action taken to put things right. The care home safeguards people from abuse, neglect and self-harm and takes action to follow up any allegations.
There are no additional outcomes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People's views are listened to and acted upon. However, some procedures are inconsistently applied, which could have an impact on how risks are managed to safeguard people.

Evidence:

We were told by the manager that there had been no complaints about the service since the last key inspection, apart from a current safeguarding issue linked to health and welfare issues. We asked how complaints would be recorded, and we were told they would be held on the individual's file. We advised that the system would be more robust if there was a central overview to track trends and frequency. It is also good practice to record concerns and the action taken to resolve them as this another form of quality assurance.

We saw from a handover sheet that there had been an incident with a person from the home trespassing on property, using equipment inappropriately, which resulted in the police intervening. We asked why CQC had not been informed of this incident as stated in the regulations of the Care Standards Act 2000. The manager told us that the incident had happened during a period when they were not working. They told us that when they returned to work they had not been informed by staff of this incident, and that staff had not completed an incident form to record the details of the event and the action taken. The provider verified after the inspection that they were aware that some staff at the home were had not followed procedures and new guidelines had

Evidence:

been implemented immediately to further minimise future occurances.

We looked through all the incident reports since our last inspection and saw that they are signed off by the manager. We saw that staff recorded reassuring people after confrontations between people living at the home, and also advising that aggressive behaviour is not acceptable. On some of the reports, the manager has indicated that people's behaviour should be addressed in one to one sessions but when we looked at records from such a session we saw that this had not happened, which indicates that staff do not always act on instructions. The provider has verified that due to the nature of people's fluctuating mood and mental state it is not always possible for the staff to follow instructions and that they have to use their professional judgement in these situations.

We heard that another person living at the home has the potential to be vulnerable to financial abuse. Records showed that the person's care manager had been informed, and we saw from the actions of staff in the office that some staff took steps to reduce the risk. However, another member of staff was not aware of this issue but checked their planned action with their colleagues who advised them of the concerns. We looked at the person's care plan but there was no guidance to staff about how the risk should be managed, which could lead to an inconsistent approach and put the service user at risk.

We looked at the policy in place to support staff in 'whistle-blowing' on poor or abusive practice. We asked where the policy was kept and saw that there was a paper copy and we were advised that staff have access to the company's intranet where the policies can be accessed. We saw that the document did not contain the details for Care Direct or CQC for staff to contact, and that the phone number for one was not kept elsewhere. The police are given as a contact but there is no local number provided, if it is not a 999 situation. We looked to see what guidance the home manager is given, and saw that that there are no timescales to make a safeguarding alert. There is also no reference to ensuring the safety of the alleged victim of abuse. However, when we spoke to the manager, they were clear about their responsibilities to ensure the safety of the service user and alert as soon as possible. They described contacting the safeguarding team for advice and we discussed how investigations by the home must be agreed by the safeguarding team first. The provider has since informed us that contact information for all agencies is accessible to staff in the main office.

We looked at how people are supported to manage their finances, and we spot checked 4 people's files and the balance of their recorded money. All were accurate

Evidence:

and transactions are well recorded. However, currently the person who records the transactions, also carries out a weekly audit. We suggested that to make this audit more robust, it would be beneficial for the second person to sign the weekly audit once they'd checked it. Additionally, since the inspection the provider has informed us that the finance department also carries out regular audits to safeguard people's interests.

Environment

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People stay in a safe and well-maintained home that is homely, clean, comfortable, pleasant and hygienic.
People stay in a home that has enough space and facilities for them to lead the life they choose and to meet their needs. The home makes sure they have the right specialist equipment that encourages and promotes their independence. Their room feels like their own, it is comfortable and they feel safe when they use it. People have enough privacy when using toilets and bathrooms.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People generally live in a comfortable, well maintained home.

Evidence:

The manager showed us the capital expenditure programme, which demonstrates that significant resources are being put into the re-furbishment of the home. For example, during a recent bout of cold weather the heating system failed but was quickly repaired. The system is old and the provider has set out a budget to completely upgrade the heating system within the next 12 months. People we spoke told us that there is a maintenance person, "XXX works 5 days a week and helps the gardener with big jobs like tree felling".

We spent time in communal areas of the home to observe staff practice and people's well being. The dining room was clean and bright with music playing which several people commented positively on and discussed with staff. The main lounge was clean with several plants, mirror, organ and a full bookshelf. New leather chairs had been purchased since we last inspected. Other areas of the home had tired looking soft furniture that is in need of replacement. There was no odour. At the random inspection in November 2009 we were told that curtains had been ordered, which would make the room much more homely for people living there. We asked the manager why there were no curtains hanging in the lounge and was told that an

Evidence:

individual had pulled the curtains down. We suggested other ways in which the curtains might be attached, for example using velcro, which if pulled down could easily be re-hung. This would ensure that people continue to live in a place that is homely.

A communal room off the front entrance continues to be locked. People again told us that they tend not to use this room, since they need to ask staff to unlock it and choose not to do this. Therefore, there are some parts of the home which people continue not to have free access to and this has the potential to create an institutional atmosphere. We have made a requirement about this under section 3.

We recognised the work of the manager in improving the appearance of the home during her two years in the role but highlighted that there are still areas of the home that have a bleak institutional appearance, such as the lower corridor at the back of the building, unappealing bathrooms and curtain less windows in the lounge. The manager told us about the plans she has for the building to make it a more attractive and homely place to live.

We case tracked a person who has continence problems. Their room had a malodour and we spent time discussing this with cleaning staff. Staff told us that they have an industrial carpet cleaner and explained that the carpet in the person's room is cleaned several times a week. However, the carpet is not robust enough to withstand the level of cleaning required and is beginning to deteriorate. We spoke to the manager about this and they told us that they are trying to find an alternative flooring for this person's room. Once fitted this would ensure that the person's room will be more comfortable and their dignity is maintained.

One of the people we case tracked said "I think this is a fantastic place. I have a big room all to myself". We looked at this person's room and saw that their bedroom door could be locked and that this had been adapted so that the individual could manage to use this themselves.

Staff told us that they had had infection and communicable disease control training within the last six months. We were shown the training matrix, which verified that this training had taken place on 22/9/09. We observed good practice being followed and saw staff using protective clothing such as gloves and aprons appropriately. Additionally, alcohol gel was being used and we were shown an emergency plan that had been developed using Department of Health Guidance about swine flu. Therefore, staffs have improved their knowledge and practice so that the risks to people living in the home are minimised as far as possible.

Staffing

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People have safe and appropriate support as there are enough competent, qualified staff on duty at all times. They have confidence in the staff at the home because checks have been done to make sure that they are suitable. People's needs are met and they are supported because staff get the right training, supervision and support they need from their managers.
People are supported by an effective staff team who understand and do what is expected of them.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Increases in the numbers, experience and skills of staff in relation to meeting physical care needs is beginning to benefit people living in the home.

Evidence:

Since the random inspection on 30th November 2009, the provider had reviewed the staffing of the home to ensure that the range of experience, qualifications and skills match the assessed needs of people living in the home. We looked at duty rosters for 4 weeks leading up to the inspection and found that additional generally qualified nurses were rostered to work every day between 9am and 6pm. Staff told us that change had was a "real benefit" and they were sharing practice and skills and also enabled psychiatrically trained staff to "concentrate on doing more community based work". For example, the nurse was able to support the person better, for whom an emergency psychiatric appointment had been made, by going with the individual.

The interactions that we observed by staff with people living at the home showed that they were good listeners and approachable. We saw that they used different approaches for different people, which worked well, and we saw that they could adapt their approach when people's mood changed. For example, one person was anxious about a health appointment, and we saw staff being reassuring and recognising the person's underlying anxiety. Later in the day, after the appointment we saw that staff

Evidence:

joked with the same person who responded well to this approach and seemed more at ease.

We saw from the training files of 6 staff working at the home that 4 people had an NVQ in care and a fifth person held a nursing qualification.

Since the last inspection, we were told that only one person has been recruited by the home. We saw that the person's recruitment file had a complete application form with a full employment history. Written references were on file and had been received prior to the person starting work, and included a previous care employer. We saw evidence of a POVA First being in place before they started work and that there was appropriate ID in place. The file was organised well, apart some misfiled information from another employee.

We looked at the training records for 6 staff working at the home, which showed that staff were generally up to date with mandatory training such as first aid, food handling and infection control. All apart from one person had received safeguarding training, which we were told by the manager also covered the mental capacity act. Staff also have access to training around supporting people with a learning disability or a mental health issues. One person had also had training in understanding diabetes.

We looked at the home five year plan for training, and the manager informed us after the inspection, that they have requested changes to the programme to make safeguarding training more robust across all staff groups.

Conduct and management of the home

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People have confidence in the care home because it is run and managed appropriately. People's opinions are central to how the home develops and reviews their practice, as the home has appropriate ways of making sure they continue to get things right. The environment is safe for people and staff because health and safety practices are carried out.

People get the right support from the care home because the manager runs it appropriately, with an open approach that makes them feel valued and respected. They are safeguarded because the home follows clear financial and accounting procedures, keeps records appropriately and makes sure staff understand the way things should be done.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

The quality of the service people receive is improving. However, risk management and communication systems are not yet effective enough, which may still put the health and safety of people living in the home at risk.

Evidence:

Although Deepdene Care has appointed a manager, they have failed to ensure that this person registered. Deepdene informed the Commission that the management structure at Woodtown House has been reviewed and were in the process of appointing a qualified nurse to be the manager. Our main concern at this inspection has centred on risk management systems. Since the random 30th November 2009, there is a slight improvement in the assessment of risks in relation to the management of people's health. However, the information gathered has not yet been used effectively or consistently to demonstrate that the risks for people are being sufficiently minimised. Therefore, we have extended the timescale so that further monitoring of this done to ensure that the requirements are fully complied with and the risks for people are minimised as far as possible. We expect this to be fully met, and if not we will be taking enforcement action to improve this service.

Evidence:

The manager gave the Commission a detailed picture of the current situation in the service, in a document entitled AQAA (Annual Quality Assurance Assessment). Supporting illustrated what the service has done in the last year, and explicitly how it is planning to improve.

We saw that the manager provides a positive role model both in her interactions with people living at the home and through her discussions regarding respecting the individuality of people living at the home and being inclusive in her approach. However, there are practices at the home that undermine this approach because of their institutional style. For example, people queuing to collect their weekly allowance and people queuing for their medication, which is administered from a hatch. We discussed alternatives with the manager, which she agreed could be trialed. We recognized that staff need a quiet area to work in and share information but suggested to the manager that the office area with its locked door created an institutional feel, with people knocking and waiting to be seen. However, we did acknowledge that during these interactions staff were respectful and ensured that people were listened to whilst being mindful not keep people waiting.

We recognised the work of the manager in improving the appearance of the home during her two years in the role but highlighted that there are still areas of the home that have a bleak institutional appearance, such as the lower corridor at the back of the building, unappealing bathrooms and curtain less windows in the lounge. The manager told us about the plans she has for the building to make it a more attractive and homely place to live.

We looked to see if people living at the home could be confident that their views underpin the review and development of the service. We saw from typed minutes that there are regular residents' meetings where people express their views and we could see examples where their suggestions had been acted upon i.e. a take-away night on Fridays. People also told us about these meetings and how they took part. We saw from one to one session that people living at the home are encouraged to offer suggestions and to discuss their views on the opportunities and support that are available to them. We also saw that there are staff meetings to cater for the different shifts at the home and we looked at the minutes from these. The manager told us that relatives are able to contribute their views on the service. They gave examples of when this had happened.

We asked about annual assurance surveys for the service. We were told that presently information is only sought from people living at the home. We were told this happens

Evidence:

quarterly and covers topics such as food or the home's environment. The outcome of the surveys are then translated into a colorful chart, and we were told this is displayed in a communal room and discussed at the next residents' meeting. Currently, the results are also set out in percentages with written comments but this information is less clear, and may benefit from stating how many people responded to each section i.e. ten people said they were very satisfied and two said they were quite satisfied and one not satisfied. There are brief action points in response to the outcomes but not a response to comments like a request for a vegan alternative for example.

We asked if the views of family, friends and professional visitors such as GPs are sought. Currently, this is through reviews for invited family members but we suggested that people should also have the option of replying anonymously and that the range of views should be increased to gain a broader picture of the service.

We saw that some staff have had access to training in report writing and generally the records we saw were appropriately detailed and written respectfully. However, there is an overall lack of consistency in the way that records are kept e.g. meal records and weight records. This is also relevant for the completion of notification forms for CQC e.g. police involvement and trespassing for one person living at the home. Information is not always stored in the most effective manner so that staff have to hunt for information, for example chiropody records, meal records and food in take records. Monthly reviews are not robust in their ability to monitor people's health and well-being.

Comprehensive Health & Safety policies and procedures were seen, including a poster displayed near to the office stating who was responsible for implementing and reviewing these. Staff we spoke to told us that they had been regular training. We were shown the induction pack and saw that completion of this had been recorded in the files we looked at. We toured the building and observed that cleaning materials were stored securely. Records of accidents were kept and showed that appropriate action had been taken. The fire log was examined and demonstrated that fire drills, had taken place regularly. Similarly, the fire alarm had also been regularly checked. People living in the home told us that the alarm was regularly checked and "they come and you've got to go" in "case there's a fire". Certificates verified that an engineer had checked the fire alarm. First aid equipment was clearly labelled. Maintenance certificates were seen for fire alarm and electrical systems. The provider had verified in information sent to the Commission that a local electrician is currently updating the electrical system and appliances have been checked for safety.

We looked at the training records for 6 staff working at the home, which showed that

Evidence:

staff were generally up to date with mandatory training such as first aid, food handling and infection control. However, records did not show that all staff had received training in moving and handling, despite several people at the home having the potential to need support in this area.

Are there any outstanding requirements from the last inspection?				
	Yes	☑	No	☐

Outstanding statutory requirements

These are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action
1	9	13(4)c	Risks to people living at Woodtown House, to include but not exclusive to, the risk of tissue breakdown, falling and choking must be identified and as far as possible be eliminated by the registered person. This will ensure that the safety of people is maintained.	15/01/2010
2	16	12(5)b	The registered person must encourage and assist staff to maintain good personal and professional relationships with people by ensuring individual rights of choice and freedom of movement are valued and respected. This will promote person centred care in a therapeutic environment that is not institutional.	22/01/2010
3	19	12	The registered person must ensure that there is a system in place to ensure all staff are aware of and are up to date with peoples health and welfare needs. This will help to ensure that peoples needs are met in the most effective way.	22/01/2010

Outstanding statutory requirements

These are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action
4	41	17(3)a	The registered person must ensure that all records relating to people living in the home are kept up to date. This will help ensure that people receive consistent care and support that meets their needs.	22/01/2010

Requirements and recommendations from this inspection:

Immediate requirements:

These are immediate requirements that were set on the day we visited this care home. The registered person had to meet these within 48 hours.

No.	Standard	Regulation	Requirement	Timescale for action

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
1	6	17	The registered person must ensure that all records relating to people living in the home are kept up to date. This requirement is repeated and the timescale has been extended. This will help ensure that people receive consistent care and support that meets their needs.	31/03/2010
2	16	12	The registered person must ensure that people's rights of choice and freedom of movement are valued and respected. In particular, but not exclusively to encouraging people to have more independence in the preparation of drinks for themselves. This requirement is repeated	31/03/2010

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
			and the timescale has been extended. This will promote person centred care in a therapeutic environment that is not institutional.	
3	19	12	The registered person must ensure that there is a system in place to ensure all staff are aware of and are up to date with peoples' health and welfare needs. This requirement is repeated. This will help to ensure that people's needs are met in the most effective way.	31/03/2010
4	19	13	Unnecessary risks to the health or safety of people are identified and so far as possible eliminated. This requirement is repeated, as it has not entirely been met. This will ensure that the health and safety of people is maintained.	12/03/2010
5	20	13	Measures must be put in place to ensure that medicines are stored within safe temperature limits as per manufacturer's guidance.	23/03/2010

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
			This will ensure that people are given medicines, which are effective.	
6	23	13	Staff must be given training to prevent people being harmed or suffering abuse or being placed at risk of harm or abuse. Safeguarding procedures will be consistently applied and people will be protected as a result of this.	31/03/2010

Recommendations

These recommendations are taken from the best practice described in the National Minimum Standards and the registered person(s) should consider them as a way of improving their service.

No	Refer to Standard	Good Practice Recommendations
1	5	People should have an individual written contract or statement of terms and conditions with the home that they have access to, which sets out clearly what the service will provide for them.
2	37	The manager should be supported to apply for registration so that they do not operate outside of the law. This will ensure that people living there are confident that the manager has appropriate qualifications, experience and competency to run the home.
3	42	People that need assistance to move and transfer should be confident that all of the staff have had up to date training and are competent to do this.

Helpline:

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