Care Quality Commission

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Woodside Care Home

Woodside Care Home, Lincoln Road, Skegness, PE25 2EA

Tel: 01754768109

Date of Inspection: 23 April 2013

Date of Publication: May 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Requirements relating to workers	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Kodali Enterprise Limited
Registered Manager	Mr. Wayne Thomas
Overview of the service	Woodside Care Home is located in the seaside town of Skegness and is close to all local amenities. It has bus and train links to major towns and cities within Lincolnshire. The home is two-storey and has car parking spaces and enclosed gardens. It can accommodate 39 people who present with problems of older age, physical disabilities and symptoms of dementia. It does not provide nursing care.
Type of service	Care home service without nursing
Regulated activities	Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 23 April 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

Professional visitor to the home

What people told us and what we found

Most people we spoke with talked positively about the staff and felt they fully supported their care needs. People told us the staff spoke with them in a calm manner and listened to them. One person said, "Staff here are so good ad kind to me." Another told us, "Staff help me walk with my frame or push me in my wheelchair but they don't hurry me." Two people raised concerns. One person told us they had not received a bath and a relative told us they had, "Raised care issues" but, "They are now resolved."

People told us they had consented to any prescribed treatment from doctors, or other health and social care professionals. They told us they had been open to options given to them by care staff about how to maintain their independence. This had not always been recorded in the care plans.

The people who used the service told us they knew how to raise a concern but no one had raised any formal complaints. One person told us, "Any issue has been resolved quickly and efficiently." The complaints policy was on display.

People were not asked their opinions about staff recruitment.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 19 June 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement

powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

People who used the service told us staff asked them each day what they wanted to do. They told us staff kept to the routines they had told them about. They said they had considered the options staff had suggested about different ways to help them maintain their independence.The people who used the service told us they had consented to all the treatment which had been prescribed by either a doctor or health or social work professional. One person said, "Staff suggested a different way of ensuring I have a balanced diet, which has worked for me and I am putting on weight." Another person told us, "Staff have helped me maintain my independence and helped me find bus routes to the town."

We reviewed three care plans of people who used the service. On one the person who used the service had signed a consent form to say they had agreed to their plan of care. We confirmed verbally with one other person, whose care plan we looked at and a relative of another person that they had consented to their plans of care. Those consents had not been written down. The provider may wish to note that all consents should be recorded to ensure people who used the service had agreed to their care and treatment needs. The records did record when changes had been made to people's plans of care and these were confirmed verbally with us by the people or relative concerned.

Information was on display in the reception area about the local advocacy scheme and how people could access their services. Leaflets were also on display informing people what they should do if they, or a relative or friend could no longer make informed decisions about their lives. Leaflets were available in an easy read format, which were in pictures and words.

Staff told us they were aware policies and procedures were in place covering the topics of the Mental Capacity Act 2005 and deprivation of liberties guidance. This ensured that staff understood how to assist a person who could not make decisions for themselves. The training records confirmed staff had received training in those topics (in October 2012 and January and February 2013) and also in dementia awareness (in January and February

2013). Staff confirmed they had been given an audit tool to complete about how they maintained people's dignity. The results had not been collated at the time of our visit.

We were shown the provider continuous assessment record which the manager had completed prior to our visit. This gave us details of how people were encouraged to make decisions for themselves until such time as they could no longer do so. The record detailed the policies in place. The records we looked at confirmed the policies were in place.

The manager told us they were reviewing the records for people who were receiving end of life care. No one was currently subject to a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) authorisation.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights but this was not always recordedor detailed in the care plans.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People's needs were assessed and they confirmed their care and treatment was planned and delivered in line with their wishes. One person told us, "I can get up when I want to which is usually 6am and go to bed when I like, usually when it's dark." Another person said, "When staff help me with my bath they are gentle with me and cover me up." However one person told us they had not had a bath for three weeks. They said, "I didn't know if I was supposed to ask or whether staff would approach me." This information was passed to the manager and the situation rectified immediately. A relative told us they had raised a couple, of what they termed, "care issues" with the manager, but they had been rectified now.

A notice was on display in the reception area outlining day care facilities which were on offer at the home. We were informed by the manager this had not yet commenced. The manager informed us there would be separate staff on duty once people started using the service.

We looked at three care plans. We were informed by staff the manager initially completed the assessments on people prior to their admission to the home. Records confirmed this. The records we looked at were not consistent in the way staff recorded events. In some care plans there were several documents which had been completed at the time of the pre-admission assessment; on others there was only half the record completed. This could lead to an incomplete assessment of people's current needs.

The daily records were task orientated outlining when people had been bathed, had meals and been dressed. They did not record what other events had taken place during the day and whether there had been any changes or not to their care plans. People told us they became involved in various social activities and relatives told us they were welcomed by staff on their visits and staff kept them informed of events. One person said, "Staff encourage me to go out and I involve myself in the local pub community."

On one record the pre admission assessment detailed the mental health status of the person; which had been very complex at times and included details of a risk to the person taking their own life. The care plan did not give any details of how this risk was to be managed by the person concerned and staff. On the same pre-admission assessment details had been given about the wishes of the person regarding their diet. Details had been recorded that the person liked an option at night to have some late night supper. This had not been included in their day or night care plans. Staff were observed asking the person how they felt that day and what they would like to do.

We saw an entry in the daily record sheet of one person, which recorded how that person had burnt their head when smoking unsupervised. The record detailed the involvement of the district nurse and the home's staff. However the accident record also detailed the involvement of a paramedic team which had not been recorded in the main set of notes. There had been no reassessment of the person's capability of being able to smoke unsupervised to prevent a similar accident occurring. The person was observed only smoking in the presence of staff in the garden, after asking for their cigarettes.

Another care plan had two records for a person's nutritional needs. This could lead to confusion for staff as no one seemed to be aware of which was the most current one to follow.

Another pre-admission assessment had recorded a person's complex dietary needs linked to their mental health status. There had been a nutritional assessment on admission and the person's weight had been recorded monthly, but there was no care plan to state how the person would be encouraged to maintain a balanced diet. There was no care plan to guide staff in what to do to assess the person's mood. The person told us staff had been helping them maintain a better diet which suited their needs and tastes.

Staff told us separate records were kept on when people had received a bath or shower and when they had been weighed. We saw those records. There were record sheets for each individual who used the service. Staff told us they were kept separate from the main records to remind staff to complete them as the events took place.

On some care plans staff had failed to include their own signatures but had included them when they had been updated. We saw several care plan reviews which the manager had completed. They admitted they had become behind in their programme and were in the process of putting a calendar together to remind them of when reviews were due. A monthly audit by the quality assurance assessor employed by the provider included a review of care plans.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

People who used the service were not asked their views about the recruitment process during this visit.

The provider had a policy on recruitment and also on recruitment of ex-offenders. These had been reviewed in September 2012. We looked at three recruitment folders of staff. The contents showed staff had followed the policy.

Each folder contained details of the staff members personal contact details, a recent photograph of them, details of their employment history and copies of utilities bills and other photographic identification, such as a passport. The records also contained a job description relevant to the person's role and details of their sick leave, other absences and annual leave cards.

Each application form had the interview notes attached of the person, plus details of the job which had been offered. The provider's policy stated they would obtain two references and a disclosure and barring service check. These were in the files we looked at. The manager told us they used another company for their disclosure and barring checks but were confident they provided a quick and efficient service.

At the time of our visit the provider was not employing any one who was subject to Home Office approval to work in this country or lived in any other European Union country. They provider did not employ apprentices or students.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available.

Reasons for our judgement

People who used the service told us they could approach any member of staff and the manager if they had any concerns. No one had had to use the formal complaints process and if any issues had been raised they had been dealt with promptly. One person said, "Staff always listen to me and help me make decisions. They have some really good ideas." Another person told us, "The manager has an open door policy, we just walk in and he stops what he is doing to talk to us."

There was a notice on display in the reception area which detailed the time of day the manager held a formal surgery in the home. This was to enable people who use the service, relatives or other visitors to book a quiet time with the manager to discuss matters important to them. Details of those surgery times were kept in individual care plans under the communication section.

The complaints policy and procedure was on display in several areas of the home. It had been reviewed in July 2012. It was in large print. The provider may wish to note it stated the Care Quality Commission (CQC) dealt with complaints, but this is not true as CQC has no direct legislation to deal with complaints. The details of the local ombudsman also needed to be included.

There was nothing listed in the complaints log.

A suggestion box was on display in the reception area which staff told us was used by people who used the service and visitors. Any suggestions were discussed at staff meetings.

Staff told us they had every confidence in the senior management staff in investigating complaints. They told us each concern would be treated confidentially and staff could only access information on a need to know basis only.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services** **How the regulation was not being met:** Staff completed pre-admission assessments of people who used the service but these were not always carried through to care plans which reflected people's current needs.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 19 June 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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