Inspection Report

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

Dewar Close

5 Beech Drive, Bilton, Rugby, CV22 7LT

Tel: 01788811724

Date of Inspection: 07 January 2014

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

Care and welfare of people who use services	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	WCS Care Group Ltd
Registered Manager	Mrs. Patricia Ann Catherine Hanlon
Overview of the service	The service is registered to provide accommodation and personal care for up to 43 older people who may have dementia.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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 inspection was part of a themed inspection programme specifically looking at the quality of care provided to support people living with dementia to maintain their physical and mental health and wellbeing. The programme looked at how providers worked together to provide care and at people's experiences of moving between care homes and hospital.

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 7 January 2014, 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 staff, received feedback from people using comment cards and reviewed information sent to us by commissioners of services.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

Thirty eight people lived at the home at the time of our inspection. Not everyone had a diagnosis of dementia, but many of the people were not able to tell us about how they were cared for and supported because of their complex needs. A relative commented, "I have always found the care to have been of good quality and the staff and managers very helpful."

We observed how people were cared for and supported. We saw that staff interacted positively with people. When staff offered people drinks and snacks, they took the opportunity to chat with them about a topic that the person was clearly interested in.

The layout of the rooms and corridors provided plenty of small, homely spaces with armchairs, books and an old fashioned radio for people to relax in. On the day of our visit people took part in several organised activities. We saw that a lot of people liked to just sit and chat with each other and care staff.

The three care staff we spoke with told us they liked working at the home. They told us they were trained in dementia care. They said, "We learnt about the different aspects of dementia so we could understand the different conditions, forms and impacts" and "It explained the effect on the brain and I got to understand people better so I can respond

more effectively."

The provider's quality monitoring system included asking people, their relatives, staff and other health professionals what they thought about the service. The provider took action to improve the quality of the service.

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

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

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

How are the needs of people with dementia assessed?

The manager told us that commissioners of care provided basic information about the person's practical and physical needs. The manager explained that they needed to meet face to face with the person, to find out about their individual needs and abilities, to make sure they could provide appropriate care and support.

The manager visited people in their own homes, or in hospital, and people's families were encouraged to take part in the assessment and care planning. The manager made sure that people who did not have close family members were supported by an advocate. An advocate is a person who explains complex information to a person to enable them to make decisions.

The manager told us, "After the assessment, a care plan is written. Listening to the person, families and friends is the starting block. You need that information, but you need to get to know the person. The priority is the person."

In the four care plans we looked at, we saw that the manager assessed people's needs and abilities and risks to their health and well-being. A member of care staff told us, "The care plans always make sense, but they are the basis. You get to know the person. People might react to the new environment. We review care plans regularly."

We saw that staff kept a daily record of how people were, so they were aware when the person's needs changed. Care staff told us, "We keep daily records and the handover book. Everything is written down" and "We do care plan reviews. We check for any changes, and score the risks." The four care plans we looked at had been reviewed regularly and changed when people's needs changed.

How is the care of people with dementia planned?

Care staff we spoke with told us, "We are all keyworkers for up to three people. We make sure everything is ok for those people, that their room is ok, organise their activities, escort them out for shopping" and "We just get to know people, their likes and dislikes. When you spend seven hours a day with people, you get to know them well."

The care plans we looked at included people's personal choices for the time they liked to get up and go to bed as well as their likes, dislikes and preferences. People's preferred daily routines were detailed and described whether people liked to get dressed before or after their breakfast, for example.

The care plans described how staff needed to support people to minimise the identified risks to people's health and well-being. The manager had determined whether people were at low, medium or high risk or having their needs met. We saw that appropriate measure were in place according to the level of identified risk. For example, staff kept food and fluid charts for people at risk of poor nutrition and charted one person's moods and behaviours because they were at risk of deteriorating mental health.

During our visit we saw that people received the support and assistance they needed. For example, we saw that one person was assisted to eat and another person's meal was put aside and then re-heated when they were ready to eat. Care records showed that people were weighed every month to make sure that any nutritional risks were identified promptly. Care of people with dementia was planned clearly and thoroughly and took account of their individual physical and mental health needs, and their personal preferences.

Are people with dementia Involved in making decisions about their care?

People we spoke with told us that they had agreed how they would be cared for and supported. One person told us, "My daughter and I had a visit from a couple of girls from here and we thrashed-out what I wanted or needed before I even stepped through the door."

The manager told us that for two people who were not able to articulate their decisions, and did not have families to represent them, their advocate was involved in making decisions about how they were cared for and supported.

Care staff told us, "If a person has dementia, we read their facial expression or body language to assess whether they are in pain" and "One person tells us they, 'itch' when they have a pain, so we give them pain relief tablets and monitor their response. We can react as needed" and "I look out for people's facial expression. I watch out for their expression and hand movements."

Care staff told us that they encouraged people to actively participate in the way they were supported. Care staff told us, "We value the little decisions that people can make. If they are not able to communicate verbally, I will hold up two nighties and ask which one they would like to wear. We value their small decisions."

Are people with dementia provided with information about their care?

One person we spoke with told us, "Everything was explained to me in a way I could understand" and "Well, I'm not as young as I once was - I tend to forget things."

We saw a copy of the home pack that was given to people or their families. The manager

told us that when people are thinking of or coming into the home, everything is explained verbally and repeated to people in a way they understand, according to their abilities. They told us that if a person doesn't understand they are encouraged to ask, no matter how many times they need to ask.

During the day of inspection we heard staff engaging in a continuous dialogue with people while they delivered care. Staff used a tone of voice and language that reassured people. We saw that people were encouraged to actively participate in walking around and eating and to take an interest in the activity around them.

How is care delivered to people with dementia?

People we spoke with told us, "The workers are lovely – every one of them" and "There's not a bad one amongst them, though of course, you get on better with some than others." We saw that staff knew people well and anticipated their needs. All the staff we observed had developed a good rapport with people.

Care staff told us, "I have had dementia training. I understand the causes and impact. I can relate to and empathise with people. I work out what makes them tick" and "I know to speak clearly, get down to the same level, fully occupy their frame of reference. People need your undivided attention. The techniques work."

We saw that staff were thoughtful and compassionate in the way they cared for and supported people. We heard staff engaging in a continuous dialogue with people while they assisted them. Staff explained what they were doing, encouraged people to help themselves and checked that the person was comfortable throughout the process and satisfied with the outcome.

Care staff told us, "We ask them and they tell us, we give them a choice. It's their home. We do whatever they are comfortable with. We are here for them." We saw that staff were patient with and kind to one person who wanted to have the same conversation on many occasions. The person took an obvious pleasure in the fact that staff were always interested in what they had to say.

A member of care staff explained that they provided 24 hour care. This meant that all staff understood they needed to provide whatever support the person needed at the time of day they needed it. They said, "People get up when they feel like it. It might be 7am or 3pm. It doesn't matter. I have learnt to go with the flow, whatever they want to do. We accept that is how it is. There is no set routine."

Is the privacy and dignity of people with dementia respected?

We observed that staff treated people with respect and supported them to maintain their dignity. Staff made sure that people were comfortable and that their clothes were adjusted appropriately when they supported people to move using a stand aid. During the day of our visit we saw that consultations with a visiting doctor and a district nurse took place in the privacy of people's own rooms.

Staff engaged with people in a professional and friendly manner. We could see that people were happy with the way that staff approached them by their expression. A member of care staff told us, "I deliver care to people, personal care, sitting and talking, preparing food, help them to bed. We ask them and they tell us, we give them a choice. We are

always listening to what people say to us." This meant that people were supported to maintain their dignity and independence.

Care staff told us that sometimes people were not in the mood to be supported with their personal hygiene needs. Care staff said, "If a person is resistant to personal care, we try with other staff. We distract, divert their attention" and "If someone presents with behaviour that challenges, you might be the problem. You can ask other staff to take over and you back out."

Cooperating with other providers ✓ Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

How does the provider work with others when providing care to people with dementia?

The manager showed us an information transfer form that staff completed whenever a person needed to be transferred to hospital or another service. The form included essential information, such as name, date of birth, GP and next of kin, as well as person centred information. The person centred information included details of the person's physical and mental health, continence, sleeping and resting needs.

We were not able to see a completed form, because they were only completed on the day of transfer, to ensure that all the information was up to date. The forms were sent with the person to the hospital or other service provider. A member of care staff told us, "I had to call an ambulance once. I completed the hospital admission form and gave it to the paramedic with a photocopy of the medicines administration record (MAR)."

The service manager told us they had reviewed the transfer information record and planned to replace it with a more person centred version. We saw the proposed form included a section written as if it were the person speaking. One section was entitled, "About me" and another page described, "My likes and dislikes", including "I enjoy, I like to read, my favourite food and drink" and "I definitely do not like." Another section described, "How I like to do things" and included "My preferred time to get up and go to bed, I want help with, I like to do on my own" and "I am good at." This meant that information about people's preferences is shared with other services, even when the person is unable to communicate them verbally.

In one of the care plans we looked at, we saw that one person had recently returned to the home after spending some time in hospital. The person's discharge notes were in their care plan. Care staff told us they read the discharge notes to make sure they knew about any changes in the person's condition or needs. They told us, "I see the discharge notes from the hospital" and "The hospital discharge form lists their medicines. We check for any changes and inform the pharmacy if they need to stop any medicines."

Are people with dementia able to obtain appropriate health and social care support?

In the care plans we looked at, we saw that the manager assessed people's health needs and identified the level of support the person needed from other health professionals. We saw that the care plans explained how staff should monitor people's health and when staff should ask doctors, district nurses or community psychiatric nurses to visit people.

One person told us they were accompanied by a care staff member when they attended hospital appointments. They said they just had to inform the home about the time and date and a worker would be there.

Staff recorded when they contacted other health professionals and the advice they gave. A member of care staff told us, "We keep behaviour charts for X and Y. We can check back when we want to know if something is a new behaviour and can share the information with other health professionals."

During the staff handover between shifts, we heard that staff were fully briefed about changes in people's moods and behaviour. Staff explained the actions they had taken during their shift and actions to be taken by the incoming staff. We heard that staff agreed who would contact doctors and district nurses and who would speak with the pharmacist and collect prescriptions.

We saw that a care staff on the incoming shift checked every one's MAR sheet had been completed appropriately before the outgoing shift staff left. Another member of staff checked that all the health and safety associated tasks had been completed and signed for by the staff that undertook the tasks. This meant that staff worked as a team to ensure that people obtained the health and social care support that they needed.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive. The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service.

Reasons for our judgement

How is the quality of dementia care monitored?

We found that the service manager regularly observed how people were cared for by using a care mapping tool produced by Bradford University. Care mapping helps staff understand how care is received by a person with dementia, to enable staff to deliver person centred care. The mapping tool included questions, such as, "What did you see, what did you discover from your audit, how has your practice changed, how were the results shared with staff?" A member of care staff we spoke with told us, "We get feedback if something can be changed." The service manager told us, "It is about quality of care, getting it right for each person."

The service manager told us about their plans to develop their quality monitoring system to make sure that everyone was encouraged to share their views. They said, "A service manager will visit every week and undertake care mapping, we will have a suggestion box in reception and a confidential hotline for staff directly to the Chief Executive Officer."

We saw that the manager kept a log of accidents, incidents and complaints. These were reported to head office and analysed. The analysis checked for causes and patterns to see if any action could be taken to avoid a reoccurrence. A member of staff told us, "If someone has an accident or an incident, we write it up in their diaries and record it on an incident form and in the accident book. The senior lead or manager checks the records and looks for patterns to assess, 'Can this be avoided?'" They told us they were always told about the analysis and any actions they should take in future.

How are the risks and benefits to people with dementia receiving care managed?

The manager told us, "Not everyone has a diagnosis of dementia, but if they do, we need to know the cause of the dementia to know how best to manage it. Risk assessments include the person's emotional needs so we can plan our approach. We involve the community psychiatric nurse (CPN)."

In the four care plans we looked at, we saw risk assessments for people's cognition, memory and motivation. We saw that the manager used a tool that was recommended by the National Clinical Practice Guideline for Dementia (NICE, 2006), to assess people's daily living skills and activity planning. The assessment enabled the manager to plan and deliver effective, enabling care and support.

In the care plans we looked at, we saw that the manager had assessed risks to people according to their needs and abilities. Each need was given a green, amber or red score. The manager told us, "Amber means we ask what extra input can we make, red means we ask what we must do. If a person has a diagnosis of dementia they will score 5 for cognition, memory and motivation." We saw that instructions for staff were more detailed for people with higher assessment scores."

Care staff we spoke with told us they were encouraged to make suggestions on a day by day basis to involve people in as many everyday activities as they were able to undertake. A member of care staff told us, "We might play cards, make cakes or go into the village. Some activities can be spontaneous, some have to be planned and arranged, because of the higher risks."

Another member of care staff told us, "One person who has dementia also has diabetes, but loves snacks, so I offer them yoghurt, plain biscuits or a sandwich. We never have to lock the cupboards, but we do move some things to a higher shelf." This meant that staff understood the risks and benefits and managed risks appropriately.

Are the views of people with dementia taken into account?

The manager told us that if a person had a diagnosis of dementia, they spoke with the person's family during their assessment of needs, to help them understand the person. In the care plans we looked at, we saw that families had provided information about people's life stories and preferences. The manager told us, "Listening to the person, families and friends is the starting block. People change, tastes change, medicines or a new environment might have an impact on the person." This meant that people's care was tailored to their current views and preferences.

The manager told us that two people who did not have close families had an independent advocate provided by the Advocacy Alliance. The advocate makes sure that the person's choices are understood and respected by service providers. This meant that the manager made sure they understood the views and wishes of people with dementia

We found that the provider regularly surveyed people and their representatives to find out what they thought of the quality of the service. A questionnaire was sent to people and their families, staff, doctors, social workers and other health professionals. The results of the survey were sent to the head office for analysis. We saw that people were asked to list the most and least impressive aspects of the service. People were invited to make suggestions for change.

The manager held an open meeting to discuss the results of the survey. One issue that was raised was laundry. Actions taken by the provider included the Chief Executive Officer undertaking laundry shifts at the service to understand what worked well or needed to change. This meant that the provider took appropriate action to respond to people's views.

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.

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