Inspection Report

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

Woodfield Care Home Limited

1 Woodfield Drive, Greetland, Halifax, HX4 8NZ

Tel: 01422377239

Date of Inspection: 29 July 2013

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Staffing	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Woodfield Care Home Ltd
Overview of the service	Woodfield Care Home is a registered nursing home providing accommodation, personal and/or nursing care for up to 36 people. Accommodation at the home is provided over three floors, which can be accessed using passenger lifts. Woodfield Care Home is in a quiet residential area of Halifax, with good local amenities close by.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures 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

We carried out this inspection to check whether Woodfield Care Home Limited had taken action to meet the following essential standards:

- Consent to care and treatment
- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Staffing
- Complaints

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 29 July 2013, observed how people were being cared for and talked with people who use the service. We talked with staff.

What people told us and what we found

On the day of our visit there were 20 people living at Woodfield Care Home, 10 of whom required nursing care. During our visit we observed people interacting with staff in the lounge area and dining room. We spoke with the home manager, operations manager, six people who lived in the home, one relative, five care staff, a nurse, the activities organiser and a visiting district nurse.

We also looked at three sets of care records and saw people's individual needs were assessed and their care and support was developed from this information.

On the day of our visit the home manager informed us that she was currently completing her application to register with the Care Quality Commission.

When we spoke with people living at the home they told us:

"It's nice to have someone to talk to, there's not a lot to do here."

"It's all kept clean and tidy, when I'm having my breakfast they come and clean my room."

"There's not a lot of entertainment, staff do come and have a chat."

"Staff come when I buzz, but it can take a long time for them to come to me."

"I would tell the manager or one of the nurses if I was unhappy; they do listen to you."

"I wanted more baths and showers, I get one a week."

"It's a friendly atmosphere; staff always have a smile on their faces."

Staff told us they felt there were enough staff to meet the needs of the people living at the home. The manager told us they had recently recruited nurses and care staff; staff numbers had been increased due to the increased occupancy at the home.

On the day of our visit the home was clean, tidy and had no malodour. A number of vacant bedrooms had been re-decorated and a lounge had been converted to a visitor's room to provide privacy for visiting family, friends or healthcare professionals.

We looked at the complaints folder and from what we saw and heard during our visit we were assured that complaints would be properly investigated and that appropriate action would be taken to resolve any problems.

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

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

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

During our visit we looked at the care files of three people living at the home. These records demonstrated that people and their relatives had been involved in the care planning process and clearly documented any decisions that had been agreed. For example we saw in the first care record that the person's daughter had signed on the 29 April 2013 to agree to contents the care plans and risk assessments. They had also signed a consent form for taking photographs.

We saw in two care records that the person and their relatives had been asked about their wishes after their death and relevant information was documented. A correctly completed Do Not Administer Cardio Pulmonary Resuscitation (DNACPR) was seen in place in the first care plan but not the other two. However, in the second care file we saw it was documented that the person's wife did not want this. Also in the second care record the Do Not Resuscitate form was a company document signed by the person. This showed the home respected and responded to people's decisions about end of life care but the documentation that in place was not consistent.

The third care file we looked at documented the person was Sikh. Their records indicated that they did not want to sit at the dining table for meals with male residents as, according to Sikh culture, women have to wait until men finish eating before they are allowed to eat. This showed people's cultural and religious beliefs were respected.

The third care file also showed that the person did not speak English. The care records documented that this person had a book with pictures to aid their understanding and help them to make choices. This showed the home made reasonable adjustments to accommodate people's communication needs.

The provider may wish to note that the first care file had a completed mental capacity

assessment (MCA) in place, the second file did not have one and the third file contained a form but it was blank. This meant people's capacity to consent to care and treatment was not being assessed consistently. When we asked the manager and operations manager about this they told us they were planning to update all the care files and they would ensure these documents were completed and included in future.

During our visit we observed the cook offering people a choice of lunch menu. We saw a menu in the dining room informing people of the menu choices for breakfast. This was updated prior to lunch to inform people of the lunch time options. Staff offered mid-morning drinks and snacks to people in the lounge. We saw there was a choice of drinks and snacks, including fruit, yogurts and biscuits. This showed people living at the home were offered choices and staff took their choices and preferences into account.

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

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

During our visit we looked at care files for three people living at the home. We saw these were comprehensive, up to date, person centred and individually tailored to meet people's needs. We saw the care files contained a number of assessments of the person's needs including moving and handling, continence, personal care, nutrition and skin integrity. Where the assessment had identified areas of need, a care plan had been put in place to instruct staff on the actions they should take to support the person in meeting their identified needs in the way they preferred. For example we saw one person's care plan for personal care was very detailed and provided staff with clear guidance about what to do and how to do it; it also included clear consideration of dignity issues.

The three care records we looked at contained details about each person's life history, likes and dislikes. For example what they liked to eat and what activities they enjoyed. We saw the care plans promoted choice for people living at the home. They also documented how people preferred to be addressed by staff. This information helped staff deliver more personalised care.

During our visit we looked in six people's bedrooms; we saw they were clean and tidy. We saw toiletries such as soap and toothpaste were available to meet their personal hygiene needs. We saw there were records of people having baths and showers; however this was not recorded in their individual care plans. The manager told us they were planning to do this in future.

In two of the three care files we looked at the people had recently lost weight. However we did see evidence that their weight was being regularly monitored and that other healthcare professionals were involved. Both people had been referred to a dietician. The most recent weight recordings for these two people showed that they were no longer losing weight. We saw evidence that health care professionals were involved in people's care. This included local GPs, the community matron, podiatrists, chiropodists and physiotherapists. This meant people's health and welfare needs were being met.

The provider may wish to note that the care files and the daily records looked at did not provide clear or consistent records of people's activities for a number of months. When we asked the activities organiser about this they told us they were planning to keep individual records for people's activities, including when they declined to join in. The lack of evidence in relation meaningful activities for people meant they may be at risk of their social and emotional needs not being met.

The provider may wish to note that, although the care plans had been reviewed regularly, some information was not accurate. For example one document stated the person needed to use a small sling but a further document stated a full body sling should be used. Inconsistencies within the care records may result in care being delivered in a way that does not ensure people's safety and welfare.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening

Reasons for our judgement

When we visited the service on 26 February 2013 we found there was a lack of evidence that people living at the home were protected from the risk of abuse. This was because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. We asked the provider to make improvements.

We went back on this visit to see whether improvements had been made.

We saw that there was a safeguarding policy on file and the whistle blowing procedure was on display in the nurses' office. When we looked at the home's file for Safeguarding of Vulnerable Adults (SoVA) we found it contained the relevant documents but the layout of the contents was confusing. When we asked the manager to explain the file and documents to us they admitted they needed to sort this file out.

When we spoke with staff about safeguarding they gave a good account of what they would do if they felt there was something happening that was not in someone's best interests. They were also able to tell us about the different kinds of abuse.

We looked at the home's training matrix and saw that nine out of the 28 staff employed at the home were not up to date with their Safeguarding of Vulnerable Adults training. When we asked the manager and operations manager about this they told us not all of the staff working at the home were familiar with, and/or competent in, using the online training package. During the morning of our visit they arranged for these nine members of staff to attend a face to face training session on the 23 August 2013. The manager also told us all staff at the home were due to undertake training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This would ensure staff who worked at the home understood this legislation.

When we spoke with staff about their safeguarding training they confirmed that they did it on the computer using an e-learning package. One of them told us "I think it's good for refresher training but not for a new person." They told us they felt that on line training was not as effective as other types of training, such as role play and face to face teaching in a classroom situation. When we asked this person whether they knew how to make a

safeguarding referral they told us they were aware that they could make a direct referral and they would look it up how to do it on the internet.

We spoke with the manager and operations manager about the feedback staff had given us about the online safeguarding training. They told us they were looking into alternative methods of delivering this training in future.

During our visit we saw evidence that the home was making appropriate safeguarding referrals and notifications correctly. This showed the home was aware of its responsibilities regarding allegations of abuse and responded appropriately.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

On the morning of our visit there were 20 people living at the home. We found that one nurse was on duty with four care assistants. During the morning we saw staff were all busy, but available to respond in a timely manner to people who required assistance. The care team was being supported by a cook, domestic, maintenance person, administrator and the home manager. There was also an activities co-ordinator at the home who worked six hours a day, Monday to Friday.

When we spoke with staff about staffing levels they told us these had recently been increased. They said this had been needed and things were a lot better since the changes had been made. We spoke with the manager and they confirmed what the staff had told us. There had previously been three carers in the morning and two in the afternoon. On the week prior to our visit this had been increased to four carers in the morning and three carers in the afternoon.

We looked at the staffing rotas for the two weeks prior to our visit and the week of our visit; these confirmed what the staff and manager had told us about the recent increase in staffing levels. We saw that staffing at the weekends was sometimes a problem and we asked the manager about this. They said the current staff at the home were flexible and would cover the extra shifts required until new permanent staff were employed. The manager told us they had not used agency staff at the home for over three months. They said they occasionally used bank nurses, and used two regular bank nurses. At the time of our visit the home was advertising for more care staff. This showed that people living at the home could expect consistency of care staff to look after them and that the home responded to the changing staffing needs of the service.

The manager told us they completed a weekly dependency profile which identified the number of staff hours required, based on the needs of the people living at the home. The operations manager confirmed this and told us the staffing levels at the home were continuously under review according to the numbers and needs of the people living there. This showed the home responded to people's changing care needs.

We looked at the training matrix which showed staff were undergoing appropriate training for their role. Training was generally up to date and included first aid, food safety, dementia, infection prevention and control and moving and handling. We also saw there

were five staff with National Vocational Qualification (NVQ) Level 2 in care and two staff with NVQ Level 3 in care. Three staff were currently undertaking the NVQ Level 2 course in care. This showed that staff were suitably trained and qualified to carry out their roles.

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.

Comments and complaints people made were responded to appropriately.

Reasons for our judgement

People were made aware of the complaints system. This was provided in a format that met their needs. People's complaints were fully investigated and resolved, where possible, to their satisfaction.

When we visited the service on 26 February 2013 we found there was a lack of evidence that comments and complaints people made were responded to appropriately. We asked the provider to make improvements.

We went back on this visit to see whether improvements had been made.

We looked at the company's 'Complaints Procedure' which was on display in the reception area; we saw this was also available in the home's complaints policy.

The manager confirmed they were the nominated contact to deal with any complaints received. They told us information about making complaints was brought to the attention of potential residents at their pre-admission assessment. The home's complaints procedure was also included in the documentation given to everyone before they came to live at the home. This showed the home brought the complaints system to the attention of people living at the home.

We looked at the complaints folder and saw details of complaints received, investigations made and actions taken. We saw that two complaints had been received since April 2013. We saw that both complaints had been thoroughly investigated by the manager and written responses had been sent to the complainants. We saw evidence of appropriate involvement of other health care professionals in one of the complaints. Records showed that both complainants had been satisfied with the outcome of their complaints.

We spoke with four people living at the home and they told us that if they were unhappy about anything they would tell the manager. They said they were confident that any problems they had would be dealt with.

We saw that monthly audits of complaints received were being carried out. These looked at the number of complaints received and the reasons why people complained. This meant

any themes or trends in the complaints received could be identified and actions taken to prevent recurrent complaints about the same issues.

From what we saw and heard during our visit we felt residents living at the home and their relatives would be able to raise concerns and know they would be listened to, and that actions would be taken to resolve any problems.

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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