Woodberry

Swift & Lasting Improvements in Care

INSPECTION REPORT

WEAVERS COURT

CQC RATING GUIDE: '**GOOD**'

Privately Commissioned Inspection for

Weavers Court

Conducted by:

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Date of Inspection:

23rd July 2024

Contents

Executive Summary

As part of the **Adore Care Homes'** quality assurance programme, additional quality monitoring visits have been commissioned from outside care professionals. This is to ensure the organisation makes use of an external eye, acting as a 'critical friend', to further improve and enhance the quality of leadership and the quality of care at their care homes. An introduction to the author is available at the end of the report.

This is the report from a day spent at **Weavers Court**, Rawdon, West Yorkshire. Weavers Court is a purpose built residential care home for older people, including people living with dementia. The home has top class facilities and opened in November 2022. This was a privately commissioned inspection visit and was my second visit to the home, following up a visit in June 2023.

The team had made excellent progress over the past year. The kind, pleasant and caring culture amongst the staff group had been enhanced and there was a really nice atmosphere throughout the home on all floors. Residents remained highly complimentary about their care, the staff team and the service. Feedback from visitors and relatives was similarly positive. The cooperation and working interplay between the staff and residents was cheerful, caring and friendly. Staff spoke highly of their colleagues and of the provider organisation. There was good evidence of residents being at the centre of the meaningful activity provision and its community involvement.

This inspection also revealed a solid level of regulatory compliance. The home was clean and well presented. Staff were properly trained and supervised. Management systems to ensure ongoing quality and continuous improvement had been implemented well, were robust and up to date. Medication systems were safe. The quality of care planning had improved, although there were a couple of issues noted with daily care records, such as repositioning records and the application of topical creams. There were two separate occasions during the day where the COSHH cupboard under the sink in the second floor kitchenette was left open. COSHH items can be harmful to people living with dementia. The whole team engaged well with the mock inspection process and were keen to learn and improve still further.

CQC Rating Guide

This is a ratings guide for this service on the basis of what was seen, heard, witnessed and experienced on the day of inspection. It is for guide purposes only. The methodology used for conducting the inspection and preparing the rating is discussed in more detail in a separate section at the end of the report:

	Inadequate	Requires Improvement	Good	Outstanding
Safe			**X**	
Effective			**X**	
Caring			**X**	
Responsive			**X**	
Well-Led			**X**	

Overall: Good

This was a very solid 'Good' rating, with no significant concerns of any note.

CQC Key Question - Safe

The following CQC quality statements apply to this key question:

- Learning culture
- Safe systems, pathways and transitions
- Safeguarding
- Involving people to manage risks
- Safe environments
- Safe and effective staffing
- Infection prevention and control
- Medicines optimisation

Staffing Levels

The home is registered for a maximum of 66 people. There were 55 people in residence on the day of my visit, approaching full occupancy. The home was laid out over three floors. The home looked after people who had residential care needs, including some who lived with dementia. Staffing levels across the home were as follows:

Ground Floor (residential care for up to 18 people, including people living with dementia – 17 in residence)
(am) 1 senior care assistant and 2 care assistants
(pm) 1 senior care assistant and 2 care assistants
(nights) 1 senior care assistant (or night care manager) and 1 care assistant

First Floor (residential care for up to 23 people, including people living with dementia – 20 in residence)
(am) 1 senior care assistant and 3 care assistants
(pm) 1 senior care assistant and 3 care assistants
(nights) 1 senior care assistant and one care assistant

Second Floor (residential care for up to 25 people, including people living with dementia – 18 in residence)
(am) 1 senior care assistant and 2 care assistants
(pm) 1 senior care assistant and 2 care assistants
(nights) 1 senior care assistant and one care assistant

There was a deputy manager on duty as well in addition to the above numbers, to 'floor manage' the home. This meant there were 11 care staff across the building during the day.

Ancillary Staff
In addition to the care staff there was one chef, one kitchen assistant, three domestic staff and one laundry assistant on duty each day. There was also a full time lifestyle manager, maintenance manager and front of house manager. The team was managed by the manager and a care manager (on leave), both of whom were supernumerary to the care staff. Hairdressing and chiropody was provided by external contractors. This was a good level of ancillary staff for a home of this size.

From my observations during the day there were plenty of staff to care for the current resident group. There were many examples of staff having the time to speak with people, listen to them and engage them in activity in addition to completing personal care tasks. The management team were happy with the above quoted staffing levels, as were care staff. Dependency monitoring was taking place, with minimum acceptable numbers displayed in reception. Dependency monitoring will continue to be used as the home moves towards full occupancy as one tool to ensure that staffing provision remains appropriate.

Staff Vacancies
The manager explained that recruitment was going very well and the home was well into its final phase. There were vacancies for care assistants, three to work early shifts, two to work late shifts and three to work nights. Some offers had already been made and provided these staff who were 'pending' made it through the recruitment checks the vacancies should be filled. The home also had a good list of employed bank staff to cover roster gaps. No agency staff were being used at the home.

Staff Recruitment files
I looked at the recruitment information for several staff recently recruited to the home. The files were stored securely, were well put together and contained almost all of the information required by regulation and other information indicative of good and safe recruitment practice, such as:

- Recent photographs
- Medical information to ensure people are fit to work
- ID
- Application forms (see below)
- Contracts
- DBS information
- Satisfactory references
- Job descriptions
- Interview notes
- Evidence of relevant qualifications

In three cases there were gaps in the declared employment histories. In Staff Member A's case that was between 1998 and 2012. In Staff Member B's case is was between 1991 and 2008 and in Staff Member C's case it was between 2016 and 2018. Each staff member must provide a full employment history, right back to the time of first employment, together with a written explanation of any gaps.

See Required Action 1.

Medication Management

The medication trolleys were kept in secure medical rooms, located on each floor. At this visit I audited the medical room on the ground floor. The systems were capably demonstrated by one of the senior staff and I found them to be safe and well-managed with good practice including:

- Keys were kept by the senior member of staff in charge.
- The trolleys were tidy, well organised and attached to the wall when not in use.
- Temperatures of the medical room and refrigerator were recorded daily and were within safe ranges.
- Cleaning schedules were completed on a daily basis.
- Medication was delivered regularly in original packaging – a non MDS approach.
- Controlled drugs were kept securely and were audited regularly. A random stock check tallied.
- PRN protocols were in place for 'as required' medication and were well written.
- 'Do not disturb' tabards were worn by staff when administering medication.
- Medication audits were conducted regularly and action plans were produced where necessary.

An electronic medication system was in place at the home. The electronic MAR system involved scanning the medication boxes prior to administration and the system generated a MAR chart. The system prompted all prescribed medication administration and so it was not possible to 'forget' any medication or not sign for it. The key to demonstrating the system is being used correctly is to ensure the stock present in the boxes and packets matches exactly the amounts recorded on the computer system. I undertook 10 random stock audits and all tallied correctly.

Open Safeguarding Cases
The manager described a constructive relationship with the local authority safeguarding team and the local authority commissioners generally. There was one open safeguarding relating to a person who had fallen in the home and subsequently died shortly afterwards in hospital. The manager reported that all of the requisite information had been provided to the local team, there had been no need for a strategy meeting and she was expecting the case to be closed following the inquest.

Premises Safety & Management
The home was clean and well-presented throughout. No unpleasant odours were noted. The home was well ventilated. Maintenance records were kept diligently. Sluice rooms were locked when not in use.

In the morning there were cleaning products and dishwasher tablets left unlocked under the sink in the second floor kitchenette in the main lounge. In the afternoon the cupboard in the same location was found unlocked again, leaving cleaning products and dishwasher tablets unattended. These items can be hazardous to people living with dementia and must be kept locked away when not in use.

See Required Action 2.

Laundry Room
This room was spacious with both an 'In' and an 'Out' door. It was clear that soiled laundry was stored correctly and washed separately on a sluice wash. Dissolvable red bags were used for safe storage and laundering.

Kitchen

The home had its last environmental health inspection and received a score of 5 – 'Very Good,' which is the highest score available. Kitchen practices were not assessed further at this inspection.

CQC Key Question - Effective

The following CQC quality statements apply to this key question:

- Assessing Needs
- Delivering evidence-based care and treatment
- How staff teams and services work together
- Supporting people to live healthier lives
- Monitoring and improving outcomes
- Consent to care and treatment

Supervision & Appraisals

The home had a clear and verifiable system for undertaking supervision and appraisals. Several supervision meeting minutes were seen in the personnel files, written up and signed by both parties.

The provider used a system called Coolcare to monitor the frequency of supervision meetings and ensure this was kept on track. Only one appraisal and five supervision meetings were showing as 'overdue.' In three of the cases the staff were off sick, so supervision could not take place. In the other three cases they were only a few days overdue and would be dealt with shortly. This meant supervision and appraisal was essentially all up to date.

All staff spoken with indicated they were well supported by the management team and the provider and they spoke positively about their jobs. Several staff compared the work favourably to working in other care homes locally. One staff member said, *"I've been here since the start. The management are great and this is the best home I've worked in."* Another staff member said, *"This is a very nice place to work, it's like home from home."*

Training

The training managers were in the building undertaking face to face induction training and other work. The training compliance figures had improved substantially since last year's inspection and mandatory training stood at **97%.**

Mandatory training subjects included advanced medication (for seniors), COSHH, dementia awareness, equality and diversity, fire drill (practical), fire safety, first aid, basic food hygiene, GDPR, health and safety, nutrition, infection control, learning

disability and autism, MCA/DoLS, moving and handling (practical), oral hygiene, PPE (practical) and safeguarding.

Mental Capacity - DoLS

The manager had a good understanding of when DoLS applications are required. DoLS applications are required for people who fall into each of the following 3 categories:

a) those who lack capacity to consent to their care and treatment in the home due to dementia or severe illness;
b) those who are not free to leave the home as and when they please (i.e. staff would stop or divert them if they tried to);
c) those who need continuous monitoring (i.e. staff control all their medication, nutritional intake, activities etc).

Eleven DoLS applications had been made for people living at the home, as most people had capacity to consent to their care. One of them had been authorised by the local supervisory body. A CQC notification had been submitted for the one application determined.

Eating and Drinking

I witnessed the lunchtime experience on the ground floor, which was a positive and well-managed experience. Much good practice was observed, including:

- Music was playing, which contributed to a convivial atmosphere.
- Plenty of staff were available to assist.
- People were given the choice of where to sit.
- Staff were wearing appropriate protective equipment in the form of washable aprons.
- Clear menus were on display and tables were nicely laid.
- Choices of drinks were offered, including beer and wine.
- Each person had a roll and butter and was offered soup for a starter course.
- Choices of main courses were given verbally, which worked for the people in question.
- Second helpings were offered when people finished their meals.

- The chef served out and interacted with everyone well.
- People were assisted appropriately and any one to one care was given unobtrusively.
- Nobody was rushed.

Premises Presentation
Entrance and Reception Area
The home had a bright and welcoming entrance and reception area, with many places to sit and either watch the world go by or wait to be seen. Reception was manned by a friendly and experienced front of house manager. The manager's office was easily accessible off the main reception. Coffee, tea and snacks were available. Newspapers were available on the bar area. Information such as the home's registration certificate, complaints policy, employers' liability information was displayed prominently. The home did not yet have a CQC rating, but this would be displayed after the first inspection.

Design and Adaptation
The home was designed and purpose built for people who have mobility restrictions. All bedrooms had en-suite toilets and wet room showers. Full assisted bathing facilities were also available on each floor. The bedrooms also had smart televisions, refrigerators, fitted furniture and the facility for a telephone line. Ample storage space was available throughout the home, including for hoists and wheelchairs.

Communal Rooms
The lounges and dining rooms were welcoming, clean and very nicely furnished. There were a variety of different lounges and dining rooms in the home, including a state-of-the-art cinema room, tea room, library, garden room, lounge and sky bar area. There was a balcony on the first floor for people to enjoy the views from the home during warm weather. There was also a fully kitted out hairdressing salon. Snack and hydration stations were available on all occupied floors.

Bedrooms
The occupied bedrooms were nicely personalised with people's own belongings and photographs of their families. This enabled them to feel settled at the home.

Garden Area
The home had secure gardens, that were well presented and maintained.

CQC Key Question - Caring

The following CQC quality statements apply to this key question:

- Kindness, compassion and dignity
- Treating people as individuals
- Independence, choice and control
- Responding to people's immediate needs
- Workforce wellbeing and enablement

Residents

There was an excellent relationship between the staff and the residents. There was plenty of good-natured banter and it was clear there was a lot of respect and thankfulness from residents for the help they received from staff. The standard of personal care was evidently high and staff were responsive when people needed attention and care. This was unchanged from my last visit and if anything had been enhanced. Feedback from residents about their home was very positive. Quotations included:

"The staff are all wonderful, even the new ones. I'm very satisfied."
"It's a hard job for them and they all do it well. They do their best in difficult circumstances."
"I work on reception sometimes. It's nice they let me do that."
"They all look after you very well."
"The food is lovely."
"I have no complaints."
"I'm happy because there are lots of females here."
"I don't like being fussed over and they respect that, which is good. I'm quite happy."

Visitors

Visiting was allowed unrestricted. Feedback from visitors was also positive. In some of the written feedback available one relative had stated, *"It's like a ten star retreat reminiscent of a luxury hotel. The facilities are top class and the staff are so kind.*"

The latest Carehome.co.uk rating was 10/10 from its first 30 reviews, which demonstrated the highest level of satisfaction about the quality of care from the people who used that website for feedback.

Dignity
I saw that the staff routinely knocked on people's bedroom doors before entering their bedrooms, indicating respect for their personal space. Call bells left within reach of people when they were spending time in their bedrooms and were answered promptly. Where people got themselves into situations where their dignity may have been compromised, due to their needs, staff responded quickly and without fuss to assist them. Continence products were stored discreetly in people's bedrooms, which was an improvement from last year's visit.

Confidentiality
Care plans were stored electronically and were password protected.

CQC Key Question – Responsive

The following CQC quality statements apply to this key question:

- Person-centred care
- Care provision, integration and continuity
- Providing information
- Listening to and involving people
- Equity in access
- Equity in experiences and outcomes
- Planning for the future

Care Plans

The care planning system being used was Person Centred Software, a well-established care planning software package. All people had detailed care plans in standard areas of care written up on the system. All of the care plans I looked at were presented in a user-friendly and readable format. They were well written and were person-centred.

Life history information was present as well as detailed information about the person's care needs. End of life plans were of a good standard. Care plans had been reviewed on a monthly basis as prompted by the system. Risk assessments were completed, with standard scoring systems to ensure that risks to people were identified and managed effectively. This included people's risk of developing pressure ulcers and of becoming malnourished (MUST & Waterlow).

Daily Care Charts

The PCS system meant that there was no need for daily care charts in paper form, as fluid charts, nightly checks and similar were recorded on the computer system. Food intake records were well kept, as were hygiene records and this meant the team was able to evidence that people were properly fed and supported with their personal care.

Resident 1's care plan said that she needed to be repositioned every four hours at night and every two hours during the day. The repositioning charts did not always show repositioning at the required frequency. For example, on 22nd July there were two gaps during the day of over 4.5 hours and one on 21st July over 5.5 hours.

See Required Action 3.

Some people required the application of emollient creams. Some of the creams were written up clearly on the PCS system and staff were prompted to apply the creams in the planned care. Other peoples' creams were not as well recorded. For example, Resident 2's entry just said "cream" and the application for the morning of the inspection visit had not been recorded on PCS.

See Required Action 4.

There was nobody living at the home who required a fluid balance chart. However, there was some slightly haphazard recording of some fluids people had taken. It was not clear why these amounts were being recorded and it left the records looking as though people were only offered low amounts. We discussed fluid records being either one thing or another. Either record all fluid amounts offered and consumed, or do not record the amounts at all if it is considered unnecessary.

Consent to Care and Treatment

The mental capacity assessments (MCAs) and best interest decision making documents had significantly improved since my last visit. Mental capacity assessments (MCAs) had been undertaken for people when there was a doubt about their capacity to consent and the care given might deprive them of their liberty. For example, in one case (BD) there were MCAs and best interest documents for the decisions of living at the home, medication and consent to personal care.

Activities Arrangements

The manager explained the activity philosophy as *"People having the freedom of choice to do exactly what they want."* This came across in the way activities were thought about. One person was a nurse and she had been encouraged to talk to nursing students about nursing in the 1940s and 1950s. She had done this regularly, getting her hair done beforehand and was looking forward to future sessions. The maintenance manager had taken the former lady captain of Rawdon golf club out for a game (and another one was on the cards) and a person had been taken to their son's wedding.

The new lifestyle manager had only worked at the home for three weeks, but presented as though she had been there much longer. This was because of the long

list of activities she was able to refer to and her ideas for the future. She spoke of arts and crafts sessions, gardening, strolls up into the town with groups of residents, armchair exercises and little children coming into the home to play and entertain the residents. She was looking at booking some different singers and performers in the future. The residents' committee was in full swing and was a self-directed group.

CQC Key Question – Well Led

The following CQC quality statements apply to this key question:

- Shared direction and culture
- Capable, compassionate and inclusive leaders
- Freedom to speak up
- Workforce equality, diversity and inclusion
- Governance, management and sustainability
- Partnerships and communities
- Learning, improvement and innovation
- Environmental sustainability – sustainable development

CQC Notifications

CQC notifications were made appropriately for deaths, serious injuries and DoLS determinations.

Registered Manager

Mariyam Jogi was registered as manager, registered as part of the home's originating application. Mariyam was an experienced manager, registered several times before with CQC.

Despite being open for well over one year, the home had not yet been inspected by CQC and was unrated. A few years ago this would have been unusual, but is now a common occurrence.

Management Audits

A robust internal auditing system was in place, as designated by the provider. The auditing system was similar to other care homes run through the Danforth Care partnership, were robust and covered a wide range of key areas. The sheer amount and depth of the auditing gave confidence the home was well run. The management team believed in the governance system and felt it helped keep them safe. Actions identified through the audits were placed on a home action plan.

Audits for June 2024 included:

- Catering audit
- Fire drill audit

- Health and safety audit
- First aid box audit
- Dining experience audit
- Night visit audit report
- Lifestyle audit
- Medication audits
- First impressions audits
- Accident and incident information, with trend analysis and graphical representation
- Falls summary
- Call bell analysis (showing very fast response times)
- Dependency analysis
- Distressed behaviour analysis
- Pressure ulcer review (x3)
- Bed rails (none)
- Wounds (x2)
- Weights and weight loss management information
- Infections review
- DoLS review
- Duty of candour cases
- Safeguarding review
- Complaints and compliments
- Equipment log
- Hoists and slings review
- Fire drill
- Maintenance review
- Staffing KPIs

Provider Visits

The manager indicated she had been very well supported by the owner and quality director. The quality director was present during the inspection undertaken her monthly governance visit. The monthly governance visit report for June 2024 was in place in the file, a detailed report showing no major concerns.

Management and Leadership Observations.
The home was being well led, at all levels and the evidence for that is presented throughout this report. The manager was clear about the philosophy of care on offer and observations confirmed what she said. The team believed that caring for people also included caring for family members. To this end the quality director had done some dementia awareness training for some of the relatives, which had been greatly appreciated.

The home had grown well and the team had made excellent progress over the past year. The kind, pleasant and caring culture amongst the staff group had been enhanced and there was a really nice atmosphere throughout the home on all floors. Residents remained highly complimentary about their care, the staff team and the service. Feedback from visitors and relatives was similarly positive. The cooperation and working interplay between the staff and residents was cheerful, caring and friendly. Staff spoke highly of their colleagues and of the provider organisation. There was good evidence of residents being at the centre of the meaningful activity provision and its community involvement.

This inspection also revealed a solid level of regulatory compliance. The home was clean and well presented. Staff were properly trained and supervised. Management systems to ensure ongoing quality and continuous improvement had been implemented well, were robust and up to date. Medication systems were safe. The quality of care planning had improved, although there were a couple of issues noted with daily care records, such as repositioning records and the application of topical creams.

There were two separate occasions during the day where the COSHH cupboard under the sink in the second floor kitchenette was left open. COSHH items can be harmful to people living with dementia.

The whole team engaged well with the mock inspection process and were keen to learn and improve still further. The home was a very pleasant place to spend a day.

Required and Recommended Actions

'Required' actions are matters picked up during the inspection process that would be either in breach of regulation, arguably in breach of regulation or issues that CQC inspectors commonly criticise if not seen as correctly implemented. The regulations in question are the HSCA 2008 (Regulated Activities) Regulations 2014, The Care Quality Commission Registration Regulations 2009 and The Mental Capacity Act 2005. There are other regulations that can be relevant, but these ones cover the vast majority of issues to consider.

Recommended actions are either minor points to consider or good practice suggestions picked up elsewhere that may enhance the service in a variety of ways. There is no imperative to implement any recommendations if the provider did not consider it necessary to do so.

Required Actions

1	Please ensure that each staff member has a full employment history, right back to the time of first employment, together with a written explanation of any gaps.
2	Please remind staff to ensure cleaning products and dishwasher tablets are kept locked away at all times when not in use.
3	Please ensure Resident 1 is repositioned as required and this is accurately recorded on the PCS system.
4	Please review all of the emollient creams at the home and make sure they are clearly recorded and set up on the PCS system so that staff are prompted to apply the creams when necessary.

Recommended Actions

	None.

Inspection Methodology

The inspection took place over one full day on site at the home. Evidence was obtained in the following forms:

- Observations of care and staff interactions with residents.
- Observations of general living and activities.
- Discussions with people who lived at the home.
- Discussions with staff who worked at the home, including management staff.
- Inspection of the internal and external environment.
- Inspection of live contemporaneous care records.
- Inspection of live contemporaneous management records.
- Inspection of medication management systems.

The main inspection focus was against compliance with the following regulations:

- HSCA 2008 (Regulated Activities) Regulations 2014.
- The Care Quality Commission Registration Regulations 2009.
- The Mental Capacity Act 2005.

Full account is also taken of the following key guidance, although this list is not designed to be exhaustive:

- CQC's recently published Single Assessment Framework (SAF) and its associated Quality Statements.
- The recently retired Key Lines of Enquiry (KLOEs), as these were always a good technical guide for what appropriate quality care looks like.
- NICE guidelines on decision making and mental capacity.
- NICE guidelines on medication management.
- A whole variety of CQC's clarification documents from over the years.
- RIDDOR guidance on reporting injuries and dangerous occurrences.

The ratings awarded for each key question are professional judgements based on over 25 years' experience of inspecting and rating care services. I believe the most meaningful rating is a 'description,' not a 'score.' It is a 'narrative judgement,' not a 'numerical calculation.' This inspection does not attempt to mimic CQC's current complex scoring system.

Introduction to Author

Simon Cavadino
Simon has worked in the provision, management and regulation of social care and healthcare services for over 25 years. He currently works with a range of different care provider organisations, offering advice on the Health and Social Care Act (2008) and its accompanying regulations. He is able to undertake detailed compliance advice work and/or senior-level management advice and coaching. Simon trades under the banner of The Woodberry Partnership.

During his career Simon has worked as an inspector for the Commission for Social Care Inspection (CSCI) and for the Care Quality Commission (CQC). He has undertaken detailed inspection, registration and enforcement work during his two spells working for the national regulator.

Simon has also worked for care provider organisations in both the private and voluntary sectors, achieving high quality services wherever he has worked. His most notable career achievement was as Director of Operations for a private sector provider, where he commissioned, built, opened and ran 25 sought-after care services for adults with a learning disability over a period of 8 years.

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