GCH (Amy Woodgate) Limited

Amy Woodgate

Inspection report

Nigel Fisher Way
Chessington
Surrey
KT9 2SN

Tel: 01895257010

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Amy Woodgate House is a care home providing personal care for up to 44 people. At the time of our inspection, there were 29 people using the service. The service supports older people living with dementia and having physical care needs. The home is arranged over 2 floors and divided into three living units each comprising a sitting and dining room with a kitchen.

People's experience of using this service and what we found
Although pre-employment checks took place before staff started working with people, job interviews were not always carried out making sure the provider checked staff's knowledge and skills before they employed them. We made a recommendation about this.

Transitioning from the previous provider had an impact on the staff team which prompted the service to review staffing levels regularly making sure they met the needs of the people they supported. People received their medicines as prescribed with dedicated trained staff to manage stock control, ordering and safe storage of medicines. Infection control practices reflected current legislation and good practice. People's care records were routinely reviewed making sure it was up to date and relevant.

The home environment was suitable for people's mental and physical needs. The staff team contacted the healthcare professionals for guidance and support when people needed it. People had a choice of what and when to eat their meals. Staff understood their responsibilities and the actions they had to take should a person's capacity was doubted to make an important decision.

People and their family members described staff as compassionate and caring. Staff knew personal information about people and what was important to them which they used to inform their practice. Where people were able to undertake tasks for themselves, staff had encouraged them to do so.

The service responded to people's choices and changing care needs as necessary to support their well-being. There was a wide range of activities facilitated at the home, encouraging people to join in and interact. The staff team used pictures, objects and easy to read documents to support people's communication needs. Systems were in place to address the concerns and complaints received as necessary.

There was a good leadership at the service, with shared responsibilities, to support the service delivery. Any areas of concern identified during the inspection were promptly addressed by the management team to ensure best practice. Lessons learnt were discussed with the staff team. Quality assurance processes were in place identifying actions to drive improvements.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This was the first inspection of the service since the new provider took over and registered the service with the CQC on 16 March 2022.

Why we inspected
This was a planned inspection based on when the service registered with us.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection program. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.
Details are in our safe findings below.

Is the service effective?

Good

The service was effective.
Details are in our effective findings below.

Is the service caring?

Good

The service was caring.
Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.
Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.
Details are in our well-Led findings below.

Amy Woodgate

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors, a specialist advisor and Expert by Experience. The specialist advisor was a nurse. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Amy Woodgate is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement dependent on their registration with us. Amy Woodgate is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post and was planning to submit an application to register.

Notice of inspection

On the first day of inspection the visit was unannounced, and we let the provide know about our second visit.

What we did before the inspection
We reviewed information we had received about the service since it was registered with us. We used this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with 9 people who used the service and 14 relatives about their experience of the care provided. We also spoke with the associate director of care quality and governance, manager and nine staff members, including unit leads, care assistants, activities coordinator, chef and domestic staff. Where people had limited verbal communication, we observed their interactions with support staff.

We reviewed a range of records. This included people's care plans and risk assessments, medicines management procedures and staff files in relation to training and recruitment data. A variety of records relating to the management of the service, including audits and policies were also reviewed.

We contacted six healthcare professionals to find out their experiences of working with this provider.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were safe and protected from avoidable harm.

Staffing and recruitment
• Staff were required to undertake pre-employment checks before they started working with people, including references and Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
• However, records were not always available to evidence the interviews being carried when selecting staff for the job. In addition, the manager of the home was not involved in the interviews and systems were not in place to evaluate the candidates during the interview process. The provider reacted swiftly by sending us a robust action plan addressing these concerns which they aimed to implement immediately.

We recommend the provider review their recruitment practices to ensure safe recruitment decisions.

• The service was in the process of transitioning from the previous provider which impacted on changes in staff and staffing levels. However, the provider took actions where necessary making sure people received safe care.
• Family members expressed concerns about the recent high staff turnover, the use of agency staff and staffing levels but thought that their relatives received the care that they needed. They said, "We're in the middle of a period of transition and lots of the existing experienced mature staff have left. I don't know anyone" and "There were more staff before the latest provider took over. The staff are rushed off their feet. They have to do everything for my [relative], feed, drink and hoist involving two people."
• Staff we spoke with thought the situation had stabilised and even though there was less staff than previously, they were able to support people safely and effectively.
• We observed staffing levels during our visits and felt that there was enough staff to meet people's needs in a timely manner. Records showed that call bells were answered in good time. One person said, "If I ring my alarm staff come quickly." Another person told us, "Staff are usually there to ask me what I would like. I don't often need to ring a bell."
• The management team told us they were in the process of recruiting new staff with the expectation to fill all the permanent posts soon. Meanwhile they used regular agency staff to cover shifts as necessary. To ensure safe care delivery, the staffing levels were regularly reviewed and calculated based on the needs of the people they supported.

Systems and processes to safeguard people from the risk of abuse
• People and their family members considered the home provided good quality care.
• We asked family members if they felt their relatives were safe. Their responses were, "Yes, I have no concerns" and "Yes, it was a huge decision to move [my relative] into a home but it was the best decision I

could have made."
• The provider had safeguarding adult's policy and procedures and staff were aware of them. Staff were trained in safeguarding and understood what to do to make sure people were safe from harm and potential abuse. There was information on display for staff about whistleblowing, including how to contact the CQC, should they have any concerns about the service delivery.
• Systems were in place to monitor any safeguarding concerns received and as necessary, actions were taken to improve practice where a shortfall was identified.

Assessing risk, safety monitoring and management
• Risks to people were thoroughly assessed and kept under review.
• Family members told us that people's care and support needs were met by the staff that assisted them. Comments included, "Most definitely", "Yes, the staff are good" and "I believe so." Healthcare professionals said, "[Staff] seem to show a good sense of duty, care and patience towards their residents" and "The staff are well informed about [people's] needs and they liaise regularly with our [name of the department] to discuss [people] related issues."
• Care records contained up to date risk assessments and risk management plans. A wide range of potential risks to people were assessed and guidance was in place to minimise risks. For example, staff identified people at risk of malnutrition and monitored their nutrition and hydration needs. They checked and recorded people's weight and fluid intake where there was a concern. Other risk assessments covered personal care, skin integrity and mental health needs.
• Staff reviewed risk assessments monthly or after any significant changes or incidents that took place.
• Fire alarm system were in place and checked regularly to ensure people's safety. Personal emergency evacuation plans for people were available in the event of emergency evacuation of the building.

Using medicines safely
• Medicines were managed consistently and safely in line with national guidance.
• Records showed that people received their medicines as prescribed. Medicine Administration Records (MAR) contained sufficient information such as photographs and allergies of each person to ensure safe administration of their medicines.
• Medicines were managed by staff who had received the relevant training and who underwent annual assessments of their competency. We observed staff being patient and kind during medicines administration.
• There were checks of medicines and audits to identify any concerns and address any shortfalls.

Preventing and controlling infection
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured that the provider was using PPE effectively and safely.
We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong
• Systems were in place to learn from safety alerts and incidents.
• There was a daily meeting for senior staff to keep on top of issues. Wider staff meetings took place monthly to discuss practice, including record keeping and key worker roles.
• Incident and accident procedures were followed by the staff team to mitigate the risk of future occurrences.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Staff knew people well, including their personal histories.
• The management team assessed individual risks associated with people's care before a person came to the home to ensure their care needs could be met safely and effectively by the provider. The manager told us they also considered the person's compatibility with other people already living at the home.
• An easy-to-follow electronic system was used to plan and monitor people's care. People's care plans had a summary page with headline information to remind staff about the most important elements associated with their care. This included social information, review dates and DNACPR being in place which is an advanced decision made by a person wishing that if their heart or breathing stopped, the healthcare team would not try to restart it.

Staff support; induction, training, skills and experience
• Systems were in place to support staff in their job.
• Staff received training to ensure they competently carried out their role responsibilities. One staff member told us that the training they completed was "the most in depth that I have ever done." Training provided included videos and practical learning in mental health, dementia, safeguarding, moving and handling and fire safety. Staff's competences were assessed on the completion of a training course. Records showed that the manager had written letters to staff who were not up to date with training, giving them a deadline for completion.
• Recently all staff had a supervision meeting with their line manager and the provider was in the process of appraising staff making sure everyone had an opportunity to discuss their developmental goals. Systems were not in place to evaluate staff's performance by observing them individually carrying out tasks.
• Staff were encouraged to specialise in different areas. On the notice board, there were pictures of the staff who took on 'Champion roles' in end-of-life care, safety and activities.

Supporting people to eat and drink enough with choice in a balanced diet
• People had the necessary support to meet their nutritional care needs.
• We saw people enjoying the food provided. One person told us, "The cake is lovely here. I like that." A family member commented, "There's always drinks available and [staff] assist [my relative] with his food which always looks and smells tasty."
• We observed positive interactions during the mealtimes. People had a choice of meals and chose their meals in the dining area which they did not have to pre-order. People had drinks within reach both during and outside mealtimes. Snacks were available between the mealtimes.
• People's food preferences were noted, and staff were aware of people's dietary needs and requirements.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People had healthcare services involved as and when they required it.
• Staff were trained to respond to emergencies. Staff knew what action they had to take in the event of a medical emergency and if they saw a person's health rapidly deteriorating.
• Records showed that staff liaised with health care professionals for guidance and support, including speech and language therapists, dieticians and podiatrists. A GP visited the service regularly to monitor people's health needs.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorizations to deprive a person of their liberty had the appropriate legal authority and were being met.

• Staff received training and understood the principles of the MCA. Staff knew the importance of obtaining people's consent before they assisted them. They asked people what they would like to wear or whether they wanted a shower or bath. One staff member told us, "I always assume that the residents have capacity. I act in the best interests of the person if they present as not having capacity."
• The service carried out assessments of people's mental capacity in relation to complex decisions such as the need for bed rails or covert medication. Health professionals were involved in those decisions.
• The manager understood how the Deprivation of Liberty Safeguards (DOLS) applied to the people who used the service and had sought DOLS authorisations where required.
There were noticeboards in the home reminding staff about the MCA principles.

Adapting service, design, decoration to meet people's needs
• The home environment was comfortable, dementia friendly and suitable for people's physical needs.
• People seemed relaxed and enjoyed listening to music playing quietly in the background. One family member told us, "I like it that the home is modern with plenty of light and a nice garden." People's rooms were individually personalised with pictures and plants from their previous homes.
• Each unit had its own dining area and lounge. The wide corridors had several quiet seating spaces and some of these areas promoted reminiscence such as a garden themed area, a shop containing goods with old-fashioned packaging and sweet jars and a music area with piano. There was a secure garden, with a variety of interest points and seating areas.
• People moved around freely and with wheelchairs and walking frames where they required it. Railings were available to support people's mobility.
• There were signs with pictures for communal rooms such as dining room, living room and toilet to support people's orientation. Toilet doors were painted in a distinct colour in line with good dementia practice.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity
• Relationships were good between staff and people.
• People enjoyed talking to staff and described them as "good", "caring" and "nice." Family members' comments included, "The staff are compassionate. You can't fault them, some of the carers I think they're fond of my [relative]" and "I feel the staff almost love my [relative], they say she's a delight. My [relative] says the staff are wonderful."
• Staff communicated with people in a warm and friendly manner, showing caring attitudes whether conversations were outwardly meaningful or not.
• Staff were patient with people. We observed staff helping people to use walking frames by positioning them correctly and waiting for the person to use them, without rushing them.
• Care records included information about the diverse characteristics of people such as age, gender, ethnicity, religious and cultural factors. This information was used by staff to promote people's equality and diversity by providing care in line with these characteristics.

Respecting and promoting people's privacy, dignity and independence
• People felt valued because their privacy, dignity and independence was promoted.
• Staff showed respect towards people. One relative told us, "Oh yes, no hesitation, the staff treat everyone with respect." A healthcare professional said, "Yes, the staff were keen to preserve the privacy and dignity of the resident that I was working with, and they held it as a priority." Staff's comments included, "During personal care I always cover the [body] parts that do not require cleaning, knock on doors, tell what I am going to do and close curtains."
• Family members told us that staff supported and encouraged their relatives to maintain their independence whenever possible, including dressing themselves. One staff member told us, "It's important to know that [people] can still do things and involve them in day-to-day things like changing tables, which they had been doing all their lives…I give a flannel to wash their own face if they are able to."
• Meals and drinks were served to people to manage independently or on a one-to-one basis as required throughout the day.

Supporting people to express their views and be involved in making decisions about their care
• People and their family members were involved in decisions about care delivery.
• Family members told us, "I am formally [my relative's] voice", "Communications here are joined up and honest" and "The home always let me know when the mental health team are going in so I can be there to ask questions and hear what they have to say."
• We saw that people were able to make their own decisions about when they wanted to get up in the

morning and have their breakfast.
• Staff we spoke with understood people's preferences and what was important to them, whether this was in relation to the activities or how they liked their hair styled.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's needs were met through good organization and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs

- Care plans were detailed and recorded people's care needs and choices.
- Family members told us that their relatives were being well cared for. Comments included, "I can find no fault at all. It's much better than her previous home. They even accompanied her to hospital when I couldn't make it" and "She's always clean and tidy. There are no smells either. [Staff] even plait her hair and put it up for her which takes time."
- Care planning focused on the person, their preferences, abilities and what they liked to do so that staff could use this information to support people appropriately. We saw instructions for cleaning dentures and records of whether or not people needed support to help clean their teeth.
- People's care records were updated regularly as their needs or wishes changed. If a person had a fall, their care plan was reviewed.
- Staff kept daily records documenting the care and support they provided to people to ensure continuous care delivery.

Since 2016 onwards all organizations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Staff were aware of and understood people's communication needs.
- People's ability to communicate was recorded in their care plans, including the support they required to have conversations. One staff member told us, "Some people are not able to say much and then you have to look for other clues about how they might be feeling or if they want anything.'"
- We saw picture menus used to help people choose their meals each day.
- There were memory boxes outside people's rooms with photos or other personalised information to help people identify their own rooms.
- Minutes of the residents' meetings were recorded in a simple language and large print. The highlights from each meeting were on a 'You said,' 'We did' board so that people could access it at any time they wished.

Supporting people to develop and maintain relationships; follow interests and to take part in activities that are socially and culturally relevant

- People were provided with a range of activities to take part in and proactively supported to engage where they wish to do so.
- Staff encouraged people to undertake activities that were important to them. One person said "I like the

dancing and music. You see, I have not sat down." A family member told us, "The person in charge of activities is very good. She encourages and uses humour to get people involved. If they don't want to be part of the group, she organises individual activities to suit, like TV or the [electronic device]." People could visit a hair salon and purchase a magazine or a movie on demand.
• There was a weekly activity program and photographs were displayed of events and parties that had recently taken place in the home, such as the Queen's Jubilee, Halloween, and Bonfire night. One family member told us, "It was [my relative's] 90th birthday recently. The home got a cake for her and the family came for tea. It was lovely."
• The service had developed community links to benefit people. A regular Church service was held at the home and a local nursery visited home to enable people to interact with the children.
• Staff were encouraged to spend time with people talking to them, going for a walk in the garden or listening to music. One staff member told us, "[The provider] gives us a lot of instruments to do activities."

Improving care quality in response to complaints or concerns
• The service treated concerns and complaints seriously.
• Relatives knew how to make a complaint and felt confident to do so if needed. Comments included, "100% [confident to raise a complaint]. The senior staff will always find the answer" and "Oh definitely, no hesitation [to raise a complaint] if something wasn't right."
• Complaints received by the service were investigated and responded to in a good time. Records showed that the service took action to put things right where needed, for example in relation to quality of meals. There were signs on noticeboards about how to make complaints.

End of life care and support
• Staff were trained and knowledgeable in palliative care.
• Records showed that appropriate support had been given with the involvement of the district nurses and the local hospice where a person was at the end-of-life care.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care

- The provider had a clear vision for the direction of the service which demonstrated a desire for people to achieve the best outcomes possible.
- There was a new manager in post who was planning to register with the CQC. The manager told us they received the necessary support from their line management in day-to-day work making sure they effectively embedded the Gold Care processes in the home while the transition from the previous provider was in progress.
- Family members felt that the manager had a good oversight of the service they managed. Comments included, "[First name of the manager] is now acting manager. She's very approachable. Their open-door policy pleases us as it means anyone in the family can pop in and see her for a short time" and "[First name of the manager] has taken over as interim manager, she's brilliant."
- Staff told us they received the necessary guidance and support from the manager to meet their role expectations. They said, "If I had any questions, [the manager] always answered. She is generally a nice person" and "This is such a nice place to work in. We are very supported."
- Regulatory requirements were followed to ensure quality and good performance of the service delivery. The CQC and local authority were notified of significant events as required.
- Care records were kept in a secure place and access was limited to those with overall responsibility for the day-to-day care of the people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider sought feedback from people and those important to them and used it to develop the service.
- There were arrangements in place to gather people's views. Residents' meetings took place that explained staff changes resulted by the new owner taking over the management of the home.
- Family members were provided with opportunities to feedback about the service delivery. Family members told us, "There's a relatives' meeting coming up on [date] where you can ask questions, raise concerns or make suggestions" and "I have to say I'm pleased to see there's now a whiteboard on the wall in [my relative's] unit for suggestions." Recently a 'Meet the manager' evening with cheese and wine was facilitated for family members where the senior managers attended to discuss the changes that were taking place in the transition from the former provider to Gold Care Homes.
- Staff were asked to complete a survey and we saw their opinions being valued by the management team

looking at ways they could make improvements following feedback. Each month the provider celebrated an employee of the month in the home.

Continuous learning and improving care; Duty of Candour
• The provider undertook quality audits to inform improvements to the service.
• Quality assurance processes in place included reviewing of people's care records, medicines management, safeguarding, complaints and health and safety at the service.
• A service improvement plan was used to record any actions arising from the audits. Dates were recorded for the actions to be completed making sure it was in good time and as quickly as possible.
• The provider reacted swiftly where an improvement was required which we identified during the inspection in relation to a person's care plan and capacity.
• The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour providers must be open and transparent if things go wrong with care and treatment. During the inspection, the management team applied duty of candour as and when required. They suitably supported the inspection team and honestly shared information with us in relation to the challenges the service was facing.

Working in partnership with others
• The service worked well in partnership with health and social care organisations, which helped to improve people's wellbeing.
• Most healthcare professionals told us they had good communication with the service.
• Records showed that the service liaised with the healthcare professionals, including GPs and district nurses, where they saw a person's health needs deteriorating.