Barchester Healthcare Homes Limited

Wimborne

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 3 and 4 September 2015 and was unannounced.

Wimborne is a care home that does not provide nursing. It provides support to up to 52 older people, some of whom are living with dementia.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risk associated with people's care were not always appropriately assessed and plans had not always been developed to ensure that staff met people's needs consistently and reduced such risks.

People confirmed they felt safe and that staff involved them in making decisions. Whilst staff knew people well, care plans were not always personalised, accurate and reflective of people's needs and preferences.

Observations demonstrated people's consent was sought before staff provided care. Staff and the registered manager demonstrated a good understanding of the Mental Capacity Act 2005. The Care Quality Commission

Summary of findings

(CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The service had submitted applications for DoLS for some people living in the home to the supervisory body.

People described staff as kind and caring. Staff treated people with respect and recognised the importance of promoting independence, dignity and privacy.

Staff demonstrated a good understanding of safeguarding people at risk. They were confident any concerns raised would be acted upon by management and knew what action to take if they were not. Medicines were managed safely.

Recruitment and selection checks were carried out and the provider ensured there were enough staff on duty to meet people's needs. Staff received an induction programme when they first started work which helped them to understand their roles and responsibilities. They felt supported through supervision, appraisal and training.

People and their relatives knew how to make a complaint and these were managed in line with the provider's policy. Systems were in place to gather people's views and assess and monitor the quality of the service. These were not always fully effective and we have made a recommendation about this.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Identified risks associated with people's care were not always assessed and plan developed to mitigate such risks.

Staff had a good understand of safeguarding. They knew what to look for and how to report both internally and externally.

Recruitment processes ensured staff were safe to work with people at risk and the provider ensured appropriate staffing levels to meet people's needs.

Medicines were managed safely.

Requires improvement

Is the service effective?
The service was effective.

Staff were well supported to understand their roles and responsibilities thorough effective supervision, appraisal and training.

Staff had a good knowledge of the Mental Capacity Act 2005 and the need for best interests decisions to be made. They demonstrated they involved people in making decisions and respected the decisions they made.

People's nutritional needs were met and they had access to healthcare professionals when they required this.

Good

Is the service caring?
The service was caring.

Staff treated people with kindness and respect. They demonstrated a good understanding of the importance of promoting independence, dignity and respect.

Good

Is the service responsive?
The service was not always responsive.

Staff knew people well but the planning of care was not personalised and did not always reflect of people's needs.

A complaints procedure was in place and people knew how to use this. We saw where concerns had been raised the registered manager had implemented the complaints procedure and people had been satisfied with the outcome.

Requires improvement

Is the service well-led?
The service was not always well led.

People's records were not always accurate and completed fully.

Requires improvement

Summary of findings

Systems were in place which monitored the service and gathered people's feedback; however some of these did not always identify issues for improvement. We have made a recommendation about this.

The manager operated an open door policy and staff were encouraged to share concerns and make suggestions.

Wimborne

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 3 and 4 September 2015 and was unannounced.

The inspection team consisted of three inspectors. Prior to the inspection we reviewed previous inspection reports and information we held about the service including notifications. A notification is information about important events which the service is required to tell us about by law. This Information helped us to identify and address potential areas of concern.

During the inspection we spoke to six people living at Wimborne and three relatives. To help us understand the experience of people who could not talk with us we spent time observing interactions between staff and people who lived in the home. We also spoke to the registered manager, six staff and a visiting health care professional. We looked at the care records for seven people and the medicines administration records for 10 people. We reviewed 11 staff files in relation to their recruitment, supervisions and appraisals, the staff training matrix and the staff duty rota for the past four weeks. We also looked at a range of records relating to the management of the service such as accidents, complaints, quality audits and policies and procedures.

Requires improvement

Is the service safe?

Our findings

Observations showed people were comfortable and relaxed with staff. Few people were able to tell us verbally about their experiences however, two people said they liked it at the home and felt safe. One relative told us 'I observed [my relative] being moved with the hoist, staff seemed professional and well trained'.

Whilst staff knew people well the assessment of risk and planning of care to implement measures to reduce such risks were not always in place. For example, for one person who accessed the community a risk assessment had been written which identified this was a high risk for the person. However, it contained no information about what the risks were and how staff could reduce such risks. An entry in this persons daily records indicated they could display behaviours which may present a risk. No assessment of the risks these presented to the person or others had been undertaken and no plan of how best to provide support at times when the person displayed the behaviours were in place. For a second person who had begun to display some risky behaviours, staff knew the potential cause but were not able to tell us about any day to day support measures. The care records contained no reference to these behaviours, how these presented, any triggers to such behaviours or how to prevent them from occurring or escalating. No assessment had been undertaken and plan developed to reduce any risks these behaviours may present

Staff confirmed that any incidents of a physical nature would be recorded on an incident sheet but incidents which involved verbal aggression were not recorded in daily notes. The registered manager confirmed this. The provider required staff to input information about incidents and accidents onto a central system which supported the monitoring of incident type and action taken. The lack of recording of incidents of verbal aggression meant an analysis of the risks and triggers did not take place in order to ensure appropriate planning of care and support

A failure to appropriately assess risk and plan support to mitigate such risks was a breach of regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Staff had a good understanding of safeguarding adults at risk. They were able to identify types and signs of potential abuse and understood the procedures to follow if they suspected abuse had occurred. For example, they were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, anonymously if necessary. One staff member told us, "I would always tell my manager if I thought someone I was looking after was at risk. I'm sure they would do something but if they didn't, I'd let the local authority know." Another staff member said, "I just wouldn't tolerate anything like that. I'd report anything straight away." Staff confirmed to us the manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence.

The provider had a system in place to assist them in assessing the level of staffing needed to meet the needs of people. The registered manager told us about the staffing levels they supplied and we saw this had been consistently provided for the four weeks prior to our visit, with four or five carers on duty per shift, in addition to two activity co-ordinators, the head of care, housekeepers, kitchen and administrative staff. The provider did not use agency staff, instead using existing staff to cover vacant shifts through the use of a 'bank' system. Staff spoken to felt there were enough staff to meet people's needs. When asked one said "Yes, there are. No doubt about that." Our observations showed staff responded quickly to people's needs and requests. Staff did not appear rushed throughout our inspection and appeared to have time to spend with people.

Records showed appropriate recruitment and selection checks had been carried out before staff began work. Applicants completed an application form and were subject to an interview. Following a successful interview, recruitment checks were carried out to help ensure only suitable staff were employed. Staff confirmed they did not start work until all recruitment checks had taken place.

Medicines were stored safely. Medicines trolleys were locked and held in a locked room. Temperatures of the room storing medicines and the medicines fridge were checked daily. Tablets and capsules were mainly administered from blister packs and most other medicines were labelled with directions for use and contained both the expiry date and the date of opening.

Only senior staff who had received the appropriate training and a competency assessment were able to administer

Requires improvement

Is the service safe?

medicines. Our observation of the medicines round showed people were given the medicines they were prescribed and asked for their consent prior to these being given.

Records showed medicines were administered as required and there were no gaps in the recording of medicines. Test results, dose changes and subsequent tests were scheduled for those people whose medicines required regular monitoring.

Good

Is the service effective?

Our findings

People told us staff asked their permission before providing care and always checked they were happy with this. One person told us the staff were “brilliant”, describing them as knowledgeable of people’s needs.

On commencing employment, all staff underwent a formal induction period. Staff records showed this process was structured around allowing staff to familiarise themselves with policies, protocols and working practices and was based on the Skills for Life Care Certificate. The Care Certificate familiarises staff with an identified set of standards that health and social care workers adhere to in their daily working life. Staff 'shadowed' more experienced staff until such time as they were confident to work alone. The staff we spoke with felt they were working in a safe environment during this time and felt well supported. One staff member told us, “I’d never done this type of work before so I did a lot of shadowing. I thought the induction was really good.”

Supervision sessions had been undertaken with staff in line with the provider’s policy. Yearly staff appraisals for all staff had been undertaken or planned. Staff said they were satisfied with the supervision and appraisal process. One staff member said, “I do feel well supported anyway but supervision really helps.” Another staff member said, “I wouldn’t wait for supervision if I had a problem but it’s there anyway. I can say what I want and tell the manager what I need to say.” All of the staff members we spoke with felt well supported in their roles.

A staff training database was in place, which monitored the training undertaken by all staff. Training was provided in a number of areas including infection control, moving and handling, safeguarding of people and the Mental Capacity Act 2005. Other courses included the administration of medicines, skin integrity and first aid. Staff told us they found the training to be useful and helped them in their role. One said “I’ve learned a lot since I’ve been here. The training is good.” Another staff member told us, “It has helped me to understand my job better.”

The Care Quality Commission monitors the operation of Deprivation of Liberty Safeguards (DoLS). We discussed the Mental Capacity Act (MCA) 2005 and DoLS with the registered manager and staff. This act provides a legal framework for protecting people who are unable to make decisions for themselves and to ensure any decisions made are in their best interest. DoLS is a part of this legislation and ensures that people can only be legally deprived of their freedom of movement when it has been authorised as being in their best interests and the least restrictive option.

The registered manager and staff demonstrated a good understanding of the MCA 2005 (The Act). Staff were able to describe the nature and types of consent, people’s right to take risks and the necessity to act in people’s best interests when required. They described the purpose of the Act to us and its potential impact on the people they were caring for. Observations throughout the inspection showed staff sought people’s consent before acting. We saw how staff respected people’s right to make their own decisions. For example, the registered manager told us how it was important for one person to access the community independently. They described how they had worked with the person, the local shops and the relative to ensure this could continue for them. Whilst staff demonstrated a good understanding of The Act, the registered manager confirmed that no mental capacity assessments had been documented.

The registered manager demonstrated knowledge of Deprivation of Liberty Safeguards (DoLS) and understood their responsibilities in relation to this. They confirmed applications to the supervisory body had been made for some people living in the home.

People said they enjoyed the food and drinks offered and there was always a choice. We observed lunch over both days. People were offered a choice of meals using a ‘show plate’. This was a smaller version of the meals on offer to support people to make a choice from a visual aid.

People could choose from a planned menu which included two hot meals with a choice of main course. If there was nothing they liked on the menu there were other options available. The cook told us people could have what they wanted. The chef had completed training to support them to ensure they were able to cater for individual’s needs. They described how they fortified foods where needed and how they ensured the right consistency was provided. Pureed meals were presented in an appetising way, and family members of a person who had pureed meals told us they enjoyed their food and it was always served with care.

Good

Is the service effective?

Staff told us there was “good communication with kitchen staff. If there’s any change in people’s diets we will let them know.” Another staff member said, “The chef is always trying new things and I know he talks to the residents a lot.”

Monthly assessments of people’s nutritional status were undertaken using the Malnutrition Universal Screening Tool (MUST). ‘MUST’ is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. We saw where people’s needs had changed staff made appropriate referrals for additional support including dietician and speech and language input.

People had access to a range of healthcare professionals including community nurses, dentists, GP, dieticians and SALT. Where needed the home requested the GP made referrals to other teams for support, including the local learning disability team. Relatives gave mixed feedback about the access to health care for people. One told us "They are very good with [my relative’s] health needs. [My relative] always sees the GP and when need be. I can’t fault it”. Another relative told us that they had had to chase the staff for a GP appointment. A health care professional we spoke with told us the staff were knowledgeable of people’s needs, made appropriate referrals for additional support at appropriate times and always followed the advice of other professionals.

Good

Is the service caring?

Our findings

One person using the service told us, "The staff are my favourite people, they are good to me, lovely people." Other people indicated or told us staff were kind and they liked living in the home. One relative told us, "We can see by their demeanour how well [my family member] is well cared for." A health care professional told us how staff demonstrated a caring approach and always promoted people's dignity and privacy.

Staff were seen to be caring. Observations showed staff treating people with kindness and affection. During conversations with people, staff spoke respectfully and in a friendly way. They chose words that the people would understand. Staff explained what they were doing and why. They used people's preferred form of address and got down to the same level as people and maintained eye contact. Staff spoke clearly and repeated things so people understood what was being said to them. People were treated with dignity and respect and they felt listened to. One person told us how staff always asked them how they were, what they wanted and checked with them that they were happy with the care they were getting. Staff responded in a caring way to difficult situations. For example, when a person became agitated, we saw staff sitting with them talking with them in a way which helped them to calm down. When another person became upset staff spoke reassuringly to the person and used appropriate touch to comfort them.

Staff demonstrated a good understanding of the need to respect people's dignity and privacy. For example, when a visiting professional arrived they encouraged and supported the person to their room for privacy. When assisting with meals or drinks staff supported with dignity and engaged with the person in the activity.

Staff recognised the importance of encouraging people's independence. One told us "I don't interfere if I think someone can do something for themselves." People were supported to maintain their independence both inside the home and in the community. Where people chose to attend outside activities and were able to without support, this was encouraged.

People, their relatives and representatives were able to contribute during resident meetings and make suggestions concerning their welfare and future service provision. However, the records did not contain a plan to decide what action would be taken as a result of the current meeting, by when and by whom. For example, a request for a particular food item had been made by people at two successive meetings but it was unclear how and when this had been acted upon. The chef confirmed the menu had been reviewed and this particular food item would be part of the menu as from the week following our inspection.

People and relatives confirmed they were asked their views about the care and support their relatives received. The manager and a member of staff told us how they were in the process of undertaking reviews of people's care with them and their relatives. They told us they had not done this for everyone yet but those meetings that had taken place discussed how they felt about living in the home and each individual care plan to see whether the person and the family agreed it reflected their needs and the support to be provided.

Requires improvement

Is the service responsive?

Our findings

People and their relatives told us they felt welcomed into the home and were asked for their views about the care provided. A healthcare professional told us they felt the staff and service were personalised, understood people's needs and were responsive to changing needs. They said they made referrals at appropriate times and always acted upon advice they were given.

Staff had a good knowledge of personalised care and were able to tell us what this meant. They knew the people they cared for and the support they needed. However, care plans were not always personalised and did not always reflect people's individual needs.

Care plans are a written document which details where a person requires support and how this should be provided by staff in order for the person to manage day to day. The registered manager and a staff member said the provider used a set format for care plans. This includes a list of care plans and assessments that must be completed for everyone. The registered manager told us the provider had recognised that this format did not always work and was in the process of reviewing this.

At times care plans were not personalised as they did not reflect the needs of the individual. For example, for one person, care plans had been written for elimination and breathing which detailed they were independent and had no support needs in these areas. Their personal hygiene care plan stated they need the support of one care worker when in the bath, however the person told us whilst they did not mind this, they found it "strange." One member of staff told us they were unsure why staff stayed with this person as they did not need support in the bath. There was no information about the reasons for this support in the care plan. The registered manager told us they had not read this plan but would review this immediately.

For a second person who had suffered bereavement we found one entry in a care plan which stated a relative had passed away. The registered manager told us about a behaviour the person had begun to display, which had started since this time and advised the social work team had requested a counsellor for the person. This support had not yet started and no care plan had been developed to support staff to understand how to consistently provide appropriate support to this person during their time of bereavement.

The registered manager told us of two other people who were receiving end of life care. They told us specific care plans were implemented when people reached end of life, to cover all their needs. They said this then replaced other care plans but these remained in the file for information only. Both plans recorded similar information that was not truly personalised. For example, they stated that the purpose of the care plan was to focus on providing relief from pain, physical and mental stress. However neither person's care plan provided detail of how this was to be achieved. The care plans detailed the number of staff required to support people with personal care but did not detail how this support was to be provided.

Whilst staff knew people well the lack of detailed planning placed people at risk of receiving care and support that did not reflect their needs or preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

However, there were care plans which contained detailed information about people's needs, their likes, dislikes and preferences. For example, one person's plan for personal care detailed what they could do for themselves, the support they need, what they liked to wear, and how they made choices.

There was a complaints procedure in place and on display in communal areas. People knew who to speak with if they had any concerns or complaints. They told us they could talk to staff and felt listened to. The complaints policy included clear guidelines on how and by when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Local Government Ombudsman and the Care Quality Commission. There had been two complaints recorded this year. We looked at documentation related to these and found the complaints had been managed in a timely and satisfactory manner.

Requires improvement

Is the service well-led?

Our findings

Relatives told us that the home had a 'good ethos' and they saw it working when they visited. People were confident to talk to staff and the manager at any time and said they felt listened to.

Records were not always accurate. For example, controlled medicines were stored safely and stock reconciled with the controlled drug register. However for one person the stock did not match the amount recorded on the persons MARS. On further investigation this was a recording error, however this had not been identified by the provider or registered manager. The registered manager and staff demonstrated a good knowledge of the MCA 2005, however where DOLS had been applied they confirmed this was for people who lacked capacity but no recorded MCA had been completed. The registered manager told us about the care records for one person and said the care plans were no longer valid as one single plan had been implemented to cover this person needs. However we noted the care plans including diet and nutrition continued to be reviewed by staff as relevant, however this plan did not reflect the content in the single care plan and could therefore create confusion. Records were mostly kept of appointments with other professionals, however we saw for one person no records had been kept about the outcome of an appointment and there was no record of the advice given or the action required.

A lack of clear, accurate and contemporaneous records regarding a person's care was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a number of systems in place to monitor the quality of the service provided.

They undertook a variety of visits to the service including "Quality First Visits" and "Regulation Team" visits. Actions from these visits informed an action plan which was held centrally by the provider with nominated managers to be accountable for the completion of these actions. An alert was sent to the manager and more senior staff including the chief executive officer when actions had not been completed within the allocated timescale. We noted that these visits did not always identify issues we had. Whilst the quality first visits sampled care records and detailed when these required action m from staff, the audits dated 20 August 2015 recorded "Mental Capacity Assessments: All done". However the registered manager confirmed and we saw that no recorded assessments were in place to evidence if people lacked capacity before submitting DoLS. The prior two visits dated 19 May 2015 stated mental capacity assessment were "N/A" (not applicable) and recorded "Not completed in home as residential", indicating the audit may not be fully effective in understanding the requirements of this legislation.

We recommend the provider review their quality visits to ensure that all aspects of these are effective at all times.

The registered manager told us about the "mystery shopper" system the provider uses. A mystery shopper is a person whose identity is concealed, who is employed to visit a service to assess its quality. We saw the report which scored the service as excellent, describing how the mystery shopper was "Blown away by the desire, passion, enthusiasm and whole experience." The provider used this system to monitor and assess the approach of staff and the manager and the quality of information provided when introducing new people to the home. In addition the provider required managers to input data into a clinical governance system which was then reviewed by a relevant team to identify patterns, trends and ensure appropriate action was taken.

The provider used a variety of systems to gain the views of others. They undertook surveys with people to gain their feedback and check they were satisfied with the service they were receiving. The 2014 results showed people were satisfied with the service they received, scoring 100% for areas such as whether people were happy living at the home and satisfied that staff understood their needs as an individual. They also held review cards which people could complete and the information was entered on to an external website. Comments reviewed provided very positive feedback about the service provided.

Staff told us the manager was open and approachable. They felt comfortable to talk to them and confident action would be taken if they had any concerns or suggestions. One staff member told us, "If I have a problem I go to the manager and they will sort it out if they can." The rota was planned to ensure that there was a senior member of staff on duty at all times. A health care professional told us that whilst they did not often engage with the registered

Requires improvement

Is the service well-led?

manager, there was a clear hierarchy in the service whereby and care staff were supported and advised by senior staff. They felt staff understood their roles and responsibilities well.

Regular meetings with staff took place and were held over two separate days to allow as many staff as possible to attend. Staff were able to contribute to the meeting and to make suggestions of importance to them. The minutes contained a review of the minutes of the previous meeting and a plan to decide what action would be taken as a result of the current meeting, by when and by whom. The staff we spoke with felt the meetings were held in an open and honest manner in which they could share ideas and raise concerns.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not ensured identified risks associated with peoples care had been appropriately assessed and plan developed to mitigate such risks. Regulation 12(1)(2)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care of service users was not always planned in a manner that met their needs and reflected their preferences. Regulation 9(1)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Service user records were not always accurate and complete. Regulation 17(c)