Maria Mallaband 15 Limited

Wyndham Hall Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 20 September 2017. It was an unannounced inspection.

Wyndham Hall is a home providing accommodation for up to 60 people who require nursing or personal care, many of who are living with dementia. On the day of our inspection 37 people were living at the home.

There was a registered manager in post. 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.

This inspection was conducted following information we received raising concerns about people's care and welfare and staffing levels.

Records were not always in place, accurate or up to date. Some information in people's care plans was conflicting or inaccurate. In some people's care plans information was not in place.

The service did not always involve people in decisions about their care. People's decisions were not always respected and acted upon. We have made a recommendation about the Mental Capacity Act (MCA) 2005.

We were greeted warmly by staff at the service who seemed genuinely pleased to see us. The atmosphere was open and friendly.

People told us they were safe. Staff understood their responsibilities in relation to safeguarding. Staff had received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in place to notify the appropriate authorities where concerns were identified.

People were supported by staff who were knowledgeable about people's needs and provided support with compassion and kindness. People received quality care that met their needs.

Where risks to people had been identified, risk assessments were in place and action had been taken to manage the risks. Staff were aware of people's needs and followed guidance to keep them safe. People received their medicines as prescribed.

There were sufficient staff to meet people's needs. Staff responded promptly where people required assistance. The service had robust recruitment procedures and conducted background checks to ensure staff were suitable for their role.

The service responded to people's changing needs. People and their families were involved in their care and

how their care progressed and developed.

Most staff spoke positively about the support they received from the registered manager. Staff supervisions and meetings were scheduled as were annual appraisals. Most staff told us the registered manager was very approachable and supportive and that there was a good level of communication within the service.

People had sufficient to eat and drink. Where people required special diets, for example, pureed or fortified meals, these were provided by kitchen staff who clearly understood the dietary needs of the people they were catering for.

There was a complaints policy and procedure in place and displayed in the home. People told us they knew how to complain. The service sought people's opinions through annual surveys.

The registered manager conducted regular audits to monitor the quality of service. Learning from these audits was used to make improvements.

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

There were sufficient staff deployed to meet people's needs.

People told us they felt safe. Staff knew how to identify and raise concerns.

Risks to people were managed and assessments were in place to reduce the risks and keep people safe. People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective

Records were not always in place, accurate and up to date.

The principles of the Mental Capacity Act (MCA) 2005 were not always followed.

People were supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further training and development.

Is the service caring?

Good

The service was caring

People benefitted from caring relationships with staff.

Staff were very kind, compassionate and respectful and treated people and their relatives with dignity and respect.

Staff gave people the time to express their wishes and respected the decisions they made.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and gave clear guidance for staff on how to support people. Staff were motivated and committed to delivering personalised care.

People's needs were assessed prior to receiving any care to make sure their needs could be met. Support needs were regularly reviewed.

Is the service well-led?

Good

The service was well led.

The service had systems in place to monitor and improve the quality of service.

Most staff spoke positively about the registered manager and told us they were approachable and supportive.

The service shared learning and looked for continuous improvement.

Wyndham Hall Care Home

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 checked whether the provider was 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.

This inspection took place on 20 September 2017 and was unannounced. The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with 11 people, four relatives, five care staff, two nurses, the chef, the deputy manager and the registered manager. We also spoke with two visiting healthcare professionals. We looked at five people's care records, five staff files and medicine administration records. We also looked at a range of records relating to the management of the service. The methods we used to gather information included pathway tracking, which is capturing the experiences of a sample of people by following a person's route through the service and getting their views on their care. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

This inspection was conducted following information we received raising concerns about people's care and welfare and staffing levels. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at information we held about the service. This included previous inspection reports and notifications we had received. Notifications are certain events that providers are required by law to tell us about.

Good

Is the service safe?

Our findings

People told us they felt safe. Comments included; "Yes, I do (feel safe), it's the care, and my daughter comes in here every day", "Yes, perfectly safe" and "Yes, I feel safe as nobody can get in and we don't even lock our doors and there are staff on duty at night". One relative commented, "Yes (person) is safe here".

People were supported by staff who could explain how they would recognise and report abuse. Staff told us they would report concerns immediately to their manager or the senior person on duty. Staff were also aware they could report externally if needed. Comments included; "I'd tell the nurse in charge and the manager. I can also call the police", "I would report concerns to the manager and safeguarding" and "I'd go to the nurse in charge, the manager and call the local authority safeguarding team". The service had systems in place to investigate concerns and report them to the appropriate authorities.

Risks to people were identified and managed. People's care records included risk assessments. Where risks were identified there were plans in place that guided staff how to support people to manage the risks. Risks assessments included areas such as: pressure damage, choking, moving and handling, nutrition and anxiety. For example, one person could not mobilise independently. The risk assessment guided staff to use 'full hoist and large sling' for all transfers. We saw this person being supported in line with this guidance.

Prior to this inspection we had received concerns about the service's management of pressure care. At this inspection we looked at how risks were managed in relation to pressure are care. One person was at risk of pressure ulcers and they had a small wound that developed prior to coming to the service. The service had referred this person to the Tissue Viability Nurse (TVN) who had provided guidance for staff on how to safely support this person. This included monitoring the person's skin daily and the use of pressure relieving equipment which was set correctly. Staff were also guided to encourage the person to reposition themselves regularly. The TVN regularly visited the person to monitor their progress and records confirmed the wound was healing.

We asked people and their relatives if there were sufficient staff to meet their needs. We received conflicting views. One person said, "When there are enough on they're ok but not always and we have agency staff but they don't know what there always doing". Another person said, "Yes, I do have a call bell and I have used it and it depends how many staff are on and I've had to wait up to over an hour but usually its 20 minutes plus". One relative told us, "I think the staffing levels are pretty good. [Person] is always clean and tidy". Another relative said, "I was here, it was at night, over an hour my mother had to wait so I went and got someone".

We asked staff if there were sufficient staff on duty to meet people's needs. Staff gave us conflicting views. One staff member said, "We do not have enough staff". Another said, "Yes I think there is enough staff. It can be tight in the afternoons but it depends what staff are on duty". A nurse told us, "Yes we have enough staff here. We manage well with what we have".

During our inspection there were sufficient staff on duty to meet people's needs. The registered manager

told us staffing levels were set by the "Dependency needs of our residents". Staff were not rushed in their duties and had time to sit and chat with people. Where people's behaviour indicated the person needed help staff responded in a timely manner to prevent the person suffering anxiety. People were assisted promptly when they called for assistance. We tested and monitored peoples' call bells throughout our inspection and found staff responded promptly. The registered manager also monitored call bell response time through the audit systems. Staff rota's confirmed planned staffing levels were consistently maintained. A visiting healthcare professional who regularly attended the home told us, "I've seen more consistency in staffing at the home over the past few months which has helped with consistency in care".

We raised the concerns of people and relatives about staffing with the registered manager who said, "We are actively recruiting and I now have new starters. Agency use is down and things are improving". We saw new staff attending training on the day of our inspection. Records confirmed staffing levels were monitored regularly by the registered manager.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and Disclosure and Barring Service checks. These checks identify if prospective staff were of good character and were suitable for their role. This allowed the registered manager to make safer recruitment decisions.

Medicines were managed safely and people received their medicines as prescribed. Medicines were kept securely in a locked trolley to ensure they were stored safely. Systems were in place to ensure stocks of medicines were managed and were safe to administer. For example, medicines dispensed in liquid forms were marked with a date of opening to ensure they were administered within the date required. Where people were prescribed 'as required' medicines there were protocols in place that detailed when the person may require the medicine. Records of medicine stocks were accurate and up to date.

We observed a medicine round. The nurse checked people's identity and explained what they were going to do before administering medicines. They then ensured the person had taken their medicine before signing the Medicine Administration Record (MAR). Staff and records confirmed staffs competency to administer medicine was regularly checked. One nurse told us, "My competency has been checked and I have no problems with medication".

Requires Improvement

Is the service effective?

Our findings

Records did not demonstrate that appropriate healthcare professionals had always been consulted when planning care. For example, one person had cream in their room. Staff told us this was applied daily to prevent dry skin. We asked to see the corresponding recording and monitoring chart relating to this person. This could not be provided. We asked if the cream was prescribed and staff confirmed the cream was non-prescribed. Staff told us that the person had been admitted into the home with the cream. There was no evidence on file of a review of this cream by the GP. We also found this person was admitted into home on a pureed diet, which then progressed to a fork mashable diet and was now on normal diet. No written information was available to support these changes. This meant we could not identify how this person's diet had progressed and whether a healthcare professional had been involved in this decision making process.

Other records did not always provide accurate detail to enable effective care to be delivered .For example, one person's care plan stated they were prescribed anticoagulant (blood thinning) medicine. We spoke with staff and established this was not accurate. This person's care plan also stated 'Does not have capacity to make decision relating to medication'. A later comment stated '[Person] does not self-administer any of his medication and prefers staff to manage this'. This meant, staff had conflicting statements that did not make it clear whether medicine was administered by staff in the person's best interests or if the person was consenting to staff managing their medicines and they had capacity to consent to this. These concerns did not impact on the care people received.

We found the Mental Capacity Act (2005) (MCA) principles were not always being followed in line with the MCA code of practise. The 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. For example, one person's pre-admission assessment stated the person was vegetarian. The care plan stated the person was 'assumed to have capacity to make own decisions regarding eating and drinking'. However, when the person requested a meat dish staff referred this request to the person's relative to make a decision. As there was no reason to doubt the person's capacity to make this decision this action was not in line with the principles of the MCA 2005.

We recommend that the registered manager refers to current guidance relating to the Mental Capacity Act (MCA) 2005.

The majority of people's care plans included mental capacity assessments around specific decisions people lacked capacity to make. Care plans detailed how people should be supported in their best interests. For example, one person's care plan identified they lacked capacity to make decisions relating to their finances but were able to make decisions related to their daily living. People's care plans identified where representatives had legal authority to make decisions on people's behalf and copies of the authority were available.

The registered manager carried out assessments to determine if people were subject to any restrictions in relation to their care. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Where restrictions were in place the registered manager had made DoLS application to the supervisory body. People's care plan detailed the restrictions in place and how people were supported to ensure any restrictions were the least restrictive. For example, one person was assessed as unsafe to 'leave the home alone'. The person's best interests had been considered and a DoLS authorisation was in place. The person was supported to take accompanied excursions outside of the home.

The service sought people's consent. For example, one person wanted bedrails to ensure they did not fall out of bed. Risks associated with bedrails had been assessed and explained to the person who had signed and dated a consent form for the use of bedrails. Throughout our inspection we saw staff seeking people's consent to support.

Staff had completed training in MCA and DoLS. We asked staff about consent and the MCA. One staff member said, "Some residents can make decisions and we go with those decisions". Another said, "Some residents memories can be unreliable, other cannot make decisions. I am patient with them and explain things for them".

People told us staff had the skills to support them effectively. People's comments included; "The staff are good overall", "Yes, it's quite nice here the staff are pretty good" and "I like it here yes I do, it's been fantastic care from the girls". One relative commented, "I think they (staff) are well trained here, they know what to do".

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff told us they had received an induction and completed training when they started working at the service. Staff training was linked to the Care Certificate. The Care Certificate is a set of standards that social care workers adhere to in their daily working life. It is a nationally recognised set of minimum standards that should be covered as part of induction training of new care workers. Induction training included fire, moving and handling, dementia and infection control. Staff were positive about the training they received and were supported to attend regular updates to ensure their skills and knowledge were kept up to date. Staff comments included; "The training is alright, it helps keep you up to date" and "It was very good training and it certainly gave me confidence". Staff had the opportunity to complete national qualifications in social and health care. One staff member said, "I asked to do my level 3 (national qualification), it took a while but now I've started it I am over the moon".

Most staff told us, and records confirmed they had effective support. Staff received regular supervision. Supervision is a one to one meeting with their line manager. Supervisions and appraisals were scheduled throughout the year. Staff comments included; "I get good support and I have regular meetings with my line manager", "Yes I am well supported here" and "I do feel supported. I get good information and updates that helps me to do my job". However, one staff member we spoke with gave a conflicting view. They said, "I'm not really supported, we do have meetings but I don't think they work. The managers don't really listen". However, we found no further evidence to support these comments.

Prior to the inspection we received concerns in relation to people's nutrition and hydration. We looked at one person's care plan which identified the person had a 'poor appetite' and could be at risk of dehydration. The risk assessment informed staff the person could 'eat and drink independently' but had 'variable needs'. Food and fluid charts were regularly maintained and recorded this person's food and fluid intake. Staff were

aware this person needed variable support.

People had access to food and drink to meet their needs. Where people had specific dietary requirements this was detailed in their care plan. People received food and drink in line with the guidance. For example, one person required a 'pureed diet' due to the risk of choking. We saw this person being supported with a meal that was of the correct consistency. Menus were prominently displayed and staff assisted people with their meal choices. The chef told us he was aware of those people with specific medical conditions such as Diabetes or those loosing weigh or gaining weight. They said, "I get weekly updates about people's needs. This includes soft, pureed or special diets and conditions such as diabetes. We meet with residents to discuss their likes and dislikes and I keep a birthday list so I can make cakes for the celebrations".

We observed the midday meal experience. This was an enjoyable, social event where the majority of people attended. Food was served hot from the kitchen and looked 'home cooked', wholesome and appetising. People were offered a choice of drinks throughout their meal. People were encouraged to eat and extra portions were available. Where people required support with their meals this was provided in a patient and compassionate fashion.

We spoke with people about the food in the home. People's comments included; "Some days not so good as the meat can be to chewy. We usually get a main course and a vegetarian course and my favourite meal is a full cooked English breakfast at weekends", "Food looks alright but I can't eat it I'm a vegetarian. I've eaten a lot of sandwiches and jacket potatoes and omelettes and take all my meals in my room", "Well what I've had of it its ok and no, I don't get hungry at night" and "Yes, the food is very good and nice and we all get a good choice of menu".

Most people were supported to maintain good health. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included the GP, Care Home Support Service (CHSS) and Speech and Language Therapist (SALT). Visits by healthcare professionals, assessments and referrals were all recorded in people's care plans. We spoke with two visiting healthcare professionals and asked them about the home. Their comments included; "They follow advice and guidance and they do listen. I find communication is good here" and "There is no major problem with referrals and I do not have any concerns regarding the care offered in the home".

Good

Is the service caring?

Our findings

People told us they enjoyed living at the home and benefitted from caring relationships with the staff. People's comments included; "We like it here, the staff are very good and caring. They are like a family to us", "The staff are caring and helpful" and "Yes, it's quite nice here the staff are pretty good". A relative commented, "I think they are brilliant here. [Person] is well cared for".

People were supported by a dedicated staff team who had genuine warmth and affection for people. Staff spoke positively about their roles and their comments included: "It is nice here with a good atmosphere and nice residents", "Oh yes I do like it here, I have really nice relationships with my residents", "Professional but caring, definitely, yes" and "I love my job and the residents are great".

People were cared for by staff who were knowledgeable about the care they required and the things that were important to them in their lives. Staff spoke with people about their careers, families and where they had lived. During our visit we saw numerous positive interactions between people and staff. For example, one person required the support of two care staff and a hoist to transfer into their wheelchair for lunch. Staff spoke discreetly to the person before fetching the hoist. Staff explained what was going to happen and reassured the person in a kind and caring way throughout the move. The person smiled at the staff supporting them and was clearly reassured by the staff's approach.

We observed staff communicating with people in a very patient and caring way, offering choices and involving people in the decisions about their care. People were given options and the time to consider and choose. For example, one person was supported to attend the dining room. We could hear the person talking and joking with the staff member who laughed with them. Another person asked a staff member for a drink. The staff member knelt down next to the person, smiled and touched the person's arm asking them what they wanted to drink. The person asked for a cup of tea and this request was promptly dealt with and tea provided.

People's independence was promoted. For example, during the lunchtime meal we saw people being encouraged to eat independently. Staff only intervened when the person needed or requested support. One person's care plan described them as being 'very independent'. However they could occasionally be reluctant to maintain their personal hygiene. Staff were advised to monitor the person and encourage them to maintain their personal hygiene. Staff spoke with us about people's independence. One said, "We let them (people) eat themselves if they can, we support them only where needed and always encourage them". Another staff member said, "I get them (person) to choose their clothes and I encourage them to be in control as much as possible. I give choices".

People's dignity and privacy were respected. When staff spoke about people to us or amongst themselves they were respectful and they displayed genuine affection. Language used in care plans was respectful. We saw people were treated with dignity and respect throughout our inspection. People were addressed by their preferred name and staff knocked on people's doors before entering. One person said, "Yes, always they are very polite and they respect our dignity and our privacy".

People's personal and medical information was protected. The provider's policy and procedures on confidentiality were available to people, relatives and staff and gave details of when and how information would be shared with other professional bodies once the person's consent had been obtained. We saw these policies and procedures had been discussed at staff meetings. Staff did not speak about people in front of other people or relatives and when staff spoke with people about their care they were quiet and discrete. When staff moved away from computer screens the screens were closed and locked prevent people's personal information from being disclosed.

The provider's equal opportunities policy was available to people, relatives and staff in the home. This stated the provider's commitment to equal opportunities and diversity. This included cultural and religious backgrounds as well as people's gender and sexual orientation.

People were involved in their care. Care plans evidenced people had signed their support plans and reviews. Where people needed specialist equipment people had been involved in the decisions. For example, where people required bedrails. One person said, "My son makes the decisions for my finances but I make my decisions on my health". We asked one relative if they felt involved in the care the person received. They said, "If there are any changes or issues that arise with [person's] care they ring me. I feel well informed and involved".

Good

Is the service responsive?

Our findings

People's needs were assessed prior to admission to the service to ensure their needs could be met. People had been involved in their assessment. Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. For example, one person liked 'perfume, body spray and watching television'. Another person liked 'gardening and sitting outside'. They also preferred 'strong tea without sugar'. Staff we spoke with were aware of people's preferences.

People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person had difficulty verbalising and could 'struggle to express their thought and wishes verbally'. Staff were guided to speak clearly and 'allow [person] to express themselves'. They were also advised to 'get [person's] attention, limit noise and distractions' and to use 'simple words and sentences'. We saw staff successfully following this guidance when communicating with this person.

Care plans and risk assessments were reviewed to reflect people's changing needs. Where people's needs changed the service sought appropriate specialist advice. For example, one person was visited by a healthcare professional. Following the visit the healthcare profession informed staff the person required some pressure relieving equipment. We observed the nurse in charge making arrangements for this equipment later that morning. Another person was referred to the GP who changed the person's medicine. This change was recorded and acted upon.

People were supported by staff committed to delivering personalised care. Staff spoke with us about how they supported people. Their comments included; "Residents have their own ideas of how they want their care. We work to them as everybody is different", "I provide support their way, and not mine" and "They (people) are all individuals with different levels of care needs and wants. I work to how people want their care and the care plan".

People were offered a range of activities including games, films, arts and crafts, musical events, pampering session's and one to one activities. People's birthdays were celebrated with cards, presents and cakes. Regular weekly church services were held in the home. On the day of our inspection a pets as therapy (PAT) dog visited the home and we saw this was a very popular event.

People told us they enjoyed the activities. Comments included; "Yes, we have been doing stuff for the harvest festival", "No, I don't get involved but sometimes they have entertainers come into the home which I go and watch in the lounge" and "We do like music". People also told us the activities coordinator had recently left. The registered manager told us they were recruiting a new activities coordinator.

The services complaints policy was displayed in the home and was given to people and their families on admission to the service. Records showed complaints were dealt with in line with the policy. People we spoke with told us they knew how to complain but none had made a complaint.

The service sought people's opinions. Surveys were sent to people and their families every year. At the time of our inspection the 2017 survey had just been sent to people and replies were expected. We saw the results of the 2016 survey which were positive.

Good

Is the service well-led?

Our findings

The registered manager monitored the quality of the service provided. A range of audits were conducted and the registered manager was supported by an area manager who regularly visited the home. Action plans were created from these audits to improve the service. For example, one audit identified some staff supervision was due and records confirmed these had been completed. Another audit identified people's call system required servicing. We saw this maintenance had been completed. The audits were aligned to the Care Quality Commission's (CQC) five domains and 'audit scores' exceeded 90%.

Most people told us they knew the registered manager. Comments included; "She's alright, yes now she's doing a good job" and "I have met her but only once". One relative commented "Yes, I think she's doing a good job". Another relative said "She (registered manager) is alright. If I need to know anything she tells me". However, one person said, "I wouldn't know them if I saw them".

People knew the registered manager who was visible around the home throughout our visit. We saw them engaging with people who greeted her warmly with genuine affection. The registered manager knew people and called them by their preferred name.

Most staff told us the registered manager was supportive and approachable. Comments included; "She is a good manager and should be respected", "She is ok, she's nice", "The manager is good, approachable and supportive. Yes she is fine" and "I find the manager very supportive". However, one staff member said, "I don't think she is supportive. She doesn't listen to staff".

Accidents and incidents were recorded and investigated. The results of investigations were analysed to look for patterns and trends. For example, following an analysis of falls two people were referred to the falls team for further assessment. The registered manager also monitored wounds and liaised with healthcare professionals to improve the provision of pressure care within the home. For example, where appropriate, referrals were made to the tissue viability nurse.

Staff shared learning through meetings, briefings and handovers. Staff met at the start of every shift to share knowledge and review people's current care needs. One staff member told us, "We do share knowledge, usually through handovers and care notes. We get well informed and I think it works well".

There was a whistle blowing policy in place that was available to staff around the home. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.