

Bolton Council

Wilfred Geere House

Inspection report

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Date of inspection visit:
21 January 2016

Date of publication:
29 February 2016

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

The unannounced inspection took place on 21 January 2016. The last inspection was undertaken on 23 April 2014 and the service was found to be meeting all requirements reviewed.

Wilfred Geere House provides dementia care and is registered to provide accommodation for up to 27 people. The home is run by Bolton Council.

There was a registered manager in place at the home. 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.

There were sufficient staff in evidence on the day of the inspection. We saw from rotas that the service responded to people's dependency levels to ensure the correct number of staff were deployed on each shift.

The service had a robust recruitment process and the induction programme was comprehensive. Training for staff was on-going.

Safeguarding policies and procedures were followed appropriately and staff were aware of these. There were two staff members who were safeguarding champions. Infection control procedures were in place and there was an infection control lead within the staff.

Health and safety measures were in place and equipment was maintained and tested regularly.

The service had an appropriate medicines policy and medication procedures were followed by staff.

The service catered for a large number of people who were living with dementia as well as some who did not have this diagnosis. We saw that people were free to walk around the building as they wished, whilst being discreetly supervised by staff. There was a dementia champion amongst the staff membership.

Care plans included a range of health and personal information and were person centred. Appropriate risk assessments were held within the care plans. Staff were aware of how to deal with incidents and accidents.

Nutritional needs were catered for and mealtimes were relaxed and well managed by the service.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and the Deprivation of Liberty Safeguards (DoLS).

We observed interactions between staff and people who used the service and saw that these were friendly, kind and courteous. People we spoke with who used the service, their relatives and visiting health

professionals, told us they were happy with the care provided.

The service endeavoured to work in an inclusive way, ensuring equality and diversity for everyone.

There was a range of activities on offer and people were given choices in the course of their daily lives.

Complaints were dealt with appropriately and learning taken from them to help improve the service. The service had received a number of compliments from people who had used the service and their relatives.

Staff and people who used the service described the management as approachable.

A number of quality audits were undertaken, issues identified and measures put in place to help ensure continual improvement to the service.

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 in evidence on the day of the inspection and we saw that the service responded to people's dependency levels.

The service had a robust recruitment process and training for staff was on-going.

Safeguarding policies and procedures were followed appropriately and staff were aware of these.

Health and safety measures were in place and equipment was maintained and tested regularly. The service had an appropriate medicines policy and medication procedures were followed by staff.

Is the service effective?

Good ●

The service was effective.

There was a robust induction programme in place for staff.

Care plans included a range of health and personal information and were person centred. Appropriate risk assessments were held within the care plans. Staff were aware of how to deal with incidents and accidents.

Nutritional needs were catered for and mealtimes were relaxed and well managed by the service.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good ●

The service was caring.

We observed interactions between staff and people who used the service and saw that these were friendly, kind and courteous.

People we spoke with who used the service, their relatives and visiting health professionals, told us they were happy with the care provided.

The service endeavoured to work in an inclusive way, ensuring equality and diversity for everyone.

Is the service responsive?

Good ●

The service was responsive.

There was a range of activities on offer and people were given choices in the course of their daily lives.

Complaints were dealt with appropriately and learning taken from them to help improve the service.

The service had received a number of compliments from people who had used the service and their relatives.

Is the service well-led?

Good ●

The service was well-led.

Staff and people who used the service described the management as approachable.

A number of quality audits were undertaken, issues identified and measures put in place to help ensure continual improvement to the service.

Current good practice guidance was followed by the service.

Wilfred Geere House

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 unannounced inspection took place on 21 January 2016. The inspection was undertaken by an adult social care inspector from the Care Quality Commission.

Prior to the inspection we looked at information we held about the service such as notifications, safeguarding concerns and whistle blowing information.

During the inspection we spoke with two people who used the service, four relatives and two health and social care professional visitors. We contacted two other professionals who are involved with the service after the inspection. We spoke with four members of care staff and the registered manager. We used a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We reviewed records at the home including three care files, three staff personnel files, meeting minutes, policies and procedures, correspondence and audits held by the service.

Is the service safe?

Our findings

On the day of the inspection there were sufficient staff to meet the needs of the people who used the service. One professional visitor we spoke with, who visited on a daily basis, told us they always saw sufficient staff on duty. We discussed how staffing levels were agreed with the registered manager, who told us that the rotas had recently been changed to ensure there were usually five members of staff per shift as well as two care supervisors. We saw evidence that the staffing had been increased to this level recently, following development group meetings where rotas had been identified as a priority. The registered manager told us they sometimes used agency staff to cover shortfalls, but always ensured they used the same agency to help with consistency. A number of new members of staff had recently been recruited and this would reduce the need to use agency staff.

The dependency of people who used the service could vary and the registered manager told us the rotas were flexible to address this. Dependency was demonstrated via colour coded stickers of red, amber and green to indicate whether each person's dependency level was high, medium or low. The stickers were in memory boxes outside each room, alongside a photograph of that person. This was a quick visual prompt for staff as they entered each room and was useful due to the constant high turnover of people who used the service.

We looked at three staff files and saw that there was a robust recruitment process in place. This included potential staff being required to complete an application form and attending for an interview if short listed. After interview, successful applicants were required to produce proof of identity and references. A Disclosure and Barring Service (DBS) was then undertaken to help ensure potential employees were suitable to work with vulnerable people.

Safeguarding policies and procedures were in place and staff we spoke with were able to identify potential safeguarding issues and were aware of how to report any concerns. There were two safeguarding champions among the staff who were responsible for keeping themselves and other staff updated on changes, disseminating information and leading on any safeguarding issues.

There was a safeguarding file with guidance included, monthly auditing of any concerns raised and actions and learning. We saw that learning had been taken from safeguarding concerns at the service, for example, training had been commissioned from the tissue viability nurse following a concern about pressure area care.

The service had an infection control lead amongst the staff who was responsible for ensuring staff were aware of infection control procedures. The service had scored 92% on a recent external infection control audit. We saw that they also had a food hygiene rating of five.

We looked at three care plans and saw that appropriate risk assessments were included to help ensure people's safe care. Each care file included a personal emergency evacuation procedure (PEEP), to ensure they would receive the assistance they required in the event of an emergency. There was also a grab file with

PEEPS included, in the office, to be used in the event of an emergency.

All staff had an understanding of the management of incidents and how to report and record incidents and accidents. Incidents and accidents were monitored and audited monthly to analyse any patterns or trends and learn from them.

We saw evidence that equipment was maintained and serviced regularly. Fire and emergency equipment was regularly tested and fire evacuations undertaken on a six monthly basis.

The service had a comprehensive medicines policy and the registered manager was able to explain the procedures for booking medicines in, ordering repeat or emergency prescriptions, safe storage and disposal of medicines. We saw that medicines were stored safely and observed some people being given their medicines in a safe way. All staff had undertaken medication training. Audits were undertaken on a monthly basis and medicines errors were dealt with in an appropriate manner. We saw that the only errors that had occurred had been clerical, recording errors rather than missed or wrongly administered medicines.

Is the service effective?

Our findings

The service was in the process of having major refurbishments when we inspected. However, the building work did not encroach on the experience of people who were using the service. We saw that people were being kept up to date on the work via staff briefings and posters for visitors. Updates were also included in letters sent out to people prior to their respite break.

The service had a lead person on dementia quality and we saw that people were free to walk around the building as they wished. There were sufficient staff to ensure people were monitored and kept safe.

Although the majority of the people who used the service were living with dementia some did not have a diagnosis of dementia. The registered manager told us that part of the refurbishments would include a conservatory for people without dementia. This would allow them to have an area where they could mix with others who were less confused and more able to converse with them. A health and social care professional we contacted said, "I think if the home has a separate area for people who do not have dementia or mild dementia, this will open to the service up to a wider range of people".

We looked at three staff files and saw evidence of a robust induction programme, which included the local authority Social Care Induction Programme (SCIP) and led into the new Care Certificate programme. This was a 12 week programme with a workbook for the staff member to complete which was then checked by their supervisor. Mandatory training was undertaken, direct observations of practice to ensure competency and introduction to policies and procedures.

Training for staff was on-going and training matrix demonstrated that mandatory and extra training courses were undertaken regularly by staff at the service. Some staff were also undertaking Qualifications and Credit Framework (QCF) qualifications which replaced the National Vocational Qualifications (NVQ). There was a lead staff member on care certificate, who was also the CQF mentor. Staff were also supported with regular supervision sessions and annual appraisals. We saw evidence of this in the staff files we looked at.

Care plans we looked at included a range of health and personal information. Monitoring charts, such as food and fluids, weights and bathing were complete and up to date. We saw that health and social care professionals were contacted when necessary to provide support and assistance for staff. We observed a staff handover which included a detailed description of each person's well-being, activities undertaken, meals and drinks and any other relevant information. As each person was being talked about a member of staff held up a photograph of that person to ensure staff were aware of who they were.

Letters sent out when people were due to come into the service for a short stay requested them to complete a "My Care Passport" document. This was to be used to gain information about people and was to be shared with hospital staff in the event of the person being admitted to hospital during their stay at the service.

We spoke with two people who used the service about the food. One told us, "The food is high quality and there is a choice". The other person said, "The food is nice and you get plenty of choice". We looked at the

menus and spoke to staff in the kitchen. They were aware of people's dietary requirements and preferences. Snacks and drinks were available throughout the day.

Quality circles were undertaken to assess the quality of various areas of service delivery. We saw that there had been a quality circle around meal delivery which had resulted in some changes to mealtimes within the service. For example, the service were trialing staff members being responsible for certain tables to help people with continuity. They had also implemented summary charts at the kitchen hatch to ensure people's special dietary requirements and special needs, such as having food cut up, were readily available to staff. We saw that people with extra requirements or who struggled with mealtimes in a noisy environment were given their meals a little earlier than other people. Staff told us this was working well and enabled people who required it to have more one to one support with food.

When observing care interactions within the service we saw that staff always sought verbal consent before delivering care and support. Staff we spoke with were able to explain how they would deal with refusals of personal care, for example coming back later to try again or trying different words.

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. The application procedures for this in care homes and hospitals are 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 authorisations to deprive a person of their liberty were being met.

The service was inspected regularly by the local authority quality assurance team. We saw an action plan following an inspection which set out actions and completion dates. One of these actions had been to update staff training around MCA and DoLS. The training matrix evidenced staff training in this area and we spoke with staff about their understanding of MCA and DoLS and looked at documentation included in people's care plans. Staff demonstrated a good understanding of the subject and records were complete and up to date. The service was working within the legal requirements of the MCA and DoLS.

The registered manager told us that there was a working group at present who were looking at the issue of restraint. Their aim was to draft a new restraint policy to ensure staff were following current best practice guidance in this area.

Is the service caring?

Our findings

We spoke with two people who used the service. One person told us, "This is my first experience. The staff are marvellous. My room is an executive room, lovely and large. It's good." The other person said, "Everything is fine for me, my room is fine. Staff are fantastic, always pleasant".

We spoke with four relatives who were visiting on the day of the inspection. One person said, "It's fantastic. [My relative] has settled in straight away. Staff always make us welcome when we visit and offer us a drink". Another relative commented, "We would like long term care for [our relative] if it was possible. We have no worries as [our relative] is happy to stay, has made friends and looks well". A third relative told us, "It has a nice atmosphere when you come in, it doesn't feel like a care home".

A visiting health care professional we spoke with said, "Staff are lovely, nothing is too much trouble". Another professional visiting the service told us, "Staff give a good account of the patients and have a good understanding of what is going on. They always find a room for patients to ensure their privacy".

Another professional we contacted said, "I have a number of people I work with who use Wilfred Geere for regular respite. None of my service users or their families have anything other than positive things to say about the care provided and say staff are caring, knowledgeable and efficient. When there have been issues, these have been raised with [the manager] and been dealt with promptly. Some of the feedback given by families has impacted on how staff provide care etc. including the use of a detailed information sheet about the service user".

The service was sensitive to the needs of people who had sensory impairments and ensured they were given their meals on the first sitting so that they could receive some extra attention and support. We were told that there were members of staff who were bi-lingual and were able to communicate with certain people who were from other cultures. We saw that the service used pictorial representations to ensure they helped people to communicate and be involved with their care and support.

The registered manager told us that a new operational policy was being devised which was supportive of equality and diversity. This policy was to be based on the National Institute for Health and Care Excellence (NICE) guidelines and good practice. It was being designed to promote enablement and maximise independence.

Current skills plans, which were part of the care plans, were produced in an easy read, pictorial format. This helped ensure people who used the service were able to be included in decisions about their care and support.

There was a service user guide produced by the service, which was available in large print as well as other languages. It was not available in an easy read format and we spoke with the registered manager about this. She agreed to look into producing the guide in an easy read or pictorial format to make it even more inclusive. We saw that the action plan following the inspection by the quality assurance team included

discussions on ensuring information was as accessible as possible to people who used the service.

Letters were sent out to each person prior to their stay at the home. There was a leaflet included which offered advice on what to bring in with them, GP arrangements during their stay at the home and updates on the progress of the refurbishments. This helped include people in the activities occurring at the service.

We observed care in the service by using 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. We saw that interactions between staff and people who used the service were respectful and courteous and that there was a relaxed and friendly atmosphere.

Is the service responsive?

Our findings

We saw that there were a range of activities on offer at the service, including crafts, jigsaws, music, chats, reminiscence, using tactile materials and dominoes. Some of the staff had undertaken "Dancing with Dementia" training and they spoke enthusiastically about how they included this in the programme of activities. There were also entertainers who visited the home on a regular basis to sing or put on a show or pantomime.

We saw that one of the quality circles undertaken had identified the need to have more formal structure to activities and spontaneous engagement with people who used the service. Staff had got together and looked at what activities worked best and were committed to a programme of activities as well as seasonal themed events.

We asked people who used the service what activities they enjoyed. One person told us, "We had a 'shin dig' last night. It was very enjoyable with all kinds of dancing. We had music – old fashioned songs and hymns. It was great". Another person said, "We watch TV, go for walks, have talks. I joined in the music last night – it was good fun". One of the relatives we spoke with told us, "They [the staff] try to involve everybody and celebrate occasions"

We saw that care plans were person centred and included people's background information, likes and dislikes. This helped staff care for the person in a more individual and personal way. There was evidence that care plans were reviewed and updated when changes occurred. All care was reviewed for people who had regular respite breaks prior to each period of respite to ensure their current needs were met.

Choices were given to people who used the service where possible. For example, people were given a choice of meals, what clothes they wanted to wear and whether they wished to take part in activities. We saw evidence that some people enjoyed a religious service and this was facilitated when possible via links with the local church.

The service had an appropriate complaints policy and procedure and we saw evidence that this was followed with both formal complaints and informal concerns being recorded and followed up. All had been dealt with in a timely manner. Learning from complaints had been added to team meeting and care supervisor meeting agendas as a permanent item following recommendations from the quality assurance inspection.

We saw some compliments received by the service. Comments included, "I would like to place on record my deep gratitude and abiding respect for the way in which you looked after my [relative]...the compassion as well as professionalism of the staff shines through..."; "A big thank you to everyone...they [the staff] all became family and friends"; "Your care and dedication to the vulnerable people you care for is a great testament to your individual qualities and professionalism".

Is the service well-led?

Our findings

There was a registered manager in place at the home. 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.

We spoke with four members of care staff who all told us the management were accessible and approachable. One staff member said, "The manager is absolutely brilliant, so are the care supervisors". People who used the service and their relatives also felt all the staff and management were approachable.

A professional we contacted, who had regular contact with the home, commented, "I would always recommend Wilfred Geere above other respite providers and am always confident that anyone I place will receive good quality care".

Regular supervision sessions were undertaken to ensure staff were up to date with training and give an opportunity to discuss any issues or development needs. Staff meetings were also held on a regular basis and we saw minutes which showed that issues such as safeguarding, service user feedback, staff issues and audits and inspections were discussed.

There was evidence that care plans were regularly reviewed. Care supervisors completed a check list to ensure everything that should be included in the plans was there. These check lists were complete and up to date.

There were a number of audits undertaken at the service, including health and safety audits, equipment checks and cleaning check lists. Accidents and incidents and falls audits were regularly carried out. We saw these were analysed to look for and address any patterns or trends. A new falls policy was being drafted at the time of our visit.

We saw that a recent quality audit had taken place which looked at the service under the Care Quality Commission (CQC) domains. This was to help prepare the service for the CQC inspection. An action plan had been produced which included updating MCA and DoLS training for staff, care plans to be made more user friendly, learning from complaints to be added to the complaints log and a performance dashboard to be produced to look at progress and improvements.

In addition to this the service undertook regular 'Walk and Talk' rounds. These involved a senior manager undertaking some quality assurance of the service. This had led to a development quality circle group, which care supervisors attended, to look at improvements from the information gathered. Areas for development gathered from feedback from relatives included the need for more activities and to improve the laundry service. We saw that improvements had been made in both of these areas and they continued to be looked at within the monthly development group meetings. Other items for discussion within this forum included information for families, welcome and discharge meetings, "this is me" documents and current

National Institute for Care Excellence (NICE) guidance. Meetings with care staff also took place to offer a forum for them to put forward ideas for service improvement.

The home had links with some community services, such as the local church. The registered manager felt more community links would be useful in the future.

Regular questionnaires were sent out to people who used the service and their relatives. We saw that an offer to speak to the manager of the service to discuss any concerns was to be added to the questionnaires. This could help resolve any concerns at an early stage to help ensure people were satisfied with the service provided.