Bolton Council

Wilfred Geere House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 15 March 2018 and was unannounced. The last inspection was undertaken on 21 January 2016 when the service was rated as 'Good'. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Wilfred Geere House is a care home which provides a respite service. There are also some 'discharge from hospital' step down beds, the aim of which is to help people to return to their own home or move in to other care settings. At the time of the inspection there was one person at the home on a long term placement. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Wilfred Geere House accommodates up to 30 people in one adapted building.

There was a registered manager 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.

People we spoke with told us they felt safe at Wilfred Geere House. There were appropriate safeguarding policies in place and staff had undertaken training.

Staff had been safely recruited. Staffing levels were flexible and there were sufficient staff to meet the needs of the people who used the service.

Systems for the handling of medicines were safe. Individual and general risk assessments were in place and health and safety records were complete and up to date. Infection control procedures were adhered to throughout the home.

People were given a thorough assessment of needs prior to admission and care files included relevant information around health needs and personal preferences. The service was working within the legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Monitoring charts for issues such as food and fluid intake were completed as required. Nutritional requirements were recorded and adhered to and people were given choices with regard to meal options.

Staff were given a thorough induction and training was on-going. Staff supervisions, appraisals and observations of practice were undertaken on a regular basis.

Throughout the day we witnessed staff interacting with kindness, patience and respect with people who used the service. Staff demonstrated a commitment to preserving people's dignity.

People who used the service and their relatives, where appropriate, were involved in the planning of their care and support. This involvement was documented in their care files.

There was a welcome leaflet which included an invitation to look around the home prior to the person's stay. There was a confidentiality policy which was appropriate and up to date. People's records were stored securely.

Care plans were person centred and preferences and choices were documented within the files. A range of activities occurred during the day and arrangements were in place to ensure people's religious and cultural needs could be met.

There was an appropriate complaints system, where any concerns or complaints were logged and follow up actions documented. Questionnaires were given to all users of the service and their families to complete on discharge. The service had received a number of thank you cards and compliments.

There was an end of life champion and a number of staff had undertaken training in end of life care.

Staff told us they felt supported by management at the home.

Accidents and incidents were recorded and the log included details of the incident, the impact and outcome.

Staff meetings took place on a regular basis. The registered manager and managers of the other 'in-house' services in Bolton regularly met to share ideas and initiatives.

A number of regular audits were undertaken. We saw that issues were identified and actions recorded appropriately.

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

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 checked 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 15 March 2018 and was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed information we held about the service. This included the previous inspection report and the provider information return (PIR). A PIR is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they are planning to make. We also reviewed the statutory notifications the CQC had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send to us without delay.

Prior to the inspection we spoke with the local authority commissioning team, the local safeguarding team and Healthwatch. Healthwatch England is the national consumer champion in health and care. This was to gain their views on the service. We did not receive any negative comments. Following the inspection we contacted four health and social care professionals who have regular contact with the home. This was to find out their experiences of the service.

During our visit we spoke with the registered manager, two care supervisors and two care assistants. We also spoke with some members of the multi-agency team, namely the enhanced respite coordinator and the GP. We observed a multi-disciplinary meeting (MDT). We spoke with two people who lived at the home. We 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. We looked around the building, including all of the communal areas, toilets, bathrooms, the kitchen, and the garden. We spent time observing the lunchtime meal in both dining rooms and watched the administration of medicines to check that this was done safely.

As part of the inspection we reviewed the care records of four people at the home. These included the records of the one long term resident, two people in respite beds and one discharge from hospital. The records included their care plans and risk assessments. We reviewed other information about the service, including records of training and supervision, three staff personnel files, meeting minutes, maintenance and servicing records and quality assurance documents.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe at Wilfred Geere House. A health and social care professional we spoke with told us, "I go into Wilfred Geere regularly with a mix of different patients and I have found the service is always safe and caring".

There were appropriate safeguarding policies and procedures in place and staff had undertaken training. Staff we spoke with demonstrated a good understanding of how to recognise, report and record any issues of concern. Records of any safeguarding issues were maintained and monitored by the registered manager.

We checked to see that staff had been safely recruited. We reviewed three staff personnel files and saw that each file contained an application form with included a full employment history, two references and confirmation of the person's identity. Checks had also been carried out with the Disclosure and Barring Service (DBS) for all applicants. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. These checks should help to ensure people are protected from the risk of unsuitable staff. We saw that the service followed appropriate disciplinary procedures and staff performance management where required.

We looked at staffing levels at the home via recent rotas. As this service catered for people having respite breaks and discharge from hospital beds it could be challenging to keep staffing levels at the exact level required at all times. However, we saw that staffing levels were flexible and the registered manager endeavoured to ensure they remained appropriate. Staff we spoke with felt there were some occasions when staffing was an issue, and agency staff were sometimes used when the service was short. The registered manager told us they had recently recruited more staff and would also be recruiting to their own bank staff to help ensure consistency. On the day of the inspection there were sufficient staff to meet the needs of the people who used the service.

We reviewed the systems in place for the safe handling of medicines. The systems for ordering, storage, administration and disposal of medicines were safe. The treatment room was clean and tidy and the temperature of the medicines fridge was checked daily. Where people required their medicines administered covertly, that is hidden in food or drink, there was documentation to evidence that this was in their best interests. We looked at Medicines Administration Record (MAR) sheets and these were completed as required. We saw that where thickeners were used when a person was at risk of choking, the exact consistency and amounts were specified along with how the person should take a drink, for example, sitting upright with a cushion behind them. Where topical creams were administered there were body maps to ensure staff knew exactly where and how the creams should be applied.

We spoke with the GP who was part of the team involved with the discharge to assess beds. She told us, "The staff see it as a failure if they have to resort to medication to sedate people" She told us staff used other techniques to try to keep people calm and happy and had a great deal of success. The GP told us this was very impressive. She also told us the staff rarely used covert medicines as they always tried to offer the medicines first before resorting to giving them covertly. We witnessed the lunchtime medicines round, when

we saw staff giving explanations to people about their medicines and using extreme patience and encouragement to ensure people took them.

Appropriate individual risk assessments were in place and these were reviewed and updated regularly to ensure they remained current. Accidents and incidents were recorded and follow up actions taken where necessary.

There was an infection control file in place with information and guidance about outbreaks. All staff had undertaken appropriate training and we saw that they used personal protective equipment (PPE) to undertake personal care task, which reduced the risk of cross infection.

Inspection of records showed that a fire risk assessment was in place and regular checks had been carried out to confirm that the fire alarm, emergency lighting and fire extinguishers were in good working order and the fire exits were kept clear. There were risk assessments in place regarding the building and environment and all appropriate health and safety certificates and maintenance records were complete and up to date. Personal emergency evacuation plans (PEEPs) were in place to outline the level of assistance each person who used the service would require in the event of an emergency. These were in a 'grab file' which would be easy to access. Staff emergency information was also kept in a file in the office.

Good

Is the service effective?

Our findings

One professional we spoke with told us, "[The home] is always clean and smells clean and fresh. Staff follow advice, encourage fluids and contact us if there are any problems. They refer [to the service] appropriately".

Each individual entering the service for respite had a thorough assessment of needs at home prior to admission. Similarly, people using the discharge to assess beds as a step down from hospital, were also thoroughly assessed to ensure their needs could be appropriately met at the home.

The registered manager told us the service had recently implemented an enhanced dementia service, whereby all service users during their stay at Wilfred Geere House were offered a multi-disciplinary team (MDT) review. This included a doctor's assessment and was expected to maximise people's health and wellbeing. A pharmacist/pharmacy technician would be onsite and available to support the care supervisors with any medication issues, they would also be reviewing people's medication whilst they were at Wilfred Geere House and offering support to family members where required, for example, training on inhaler technique.

Staff were given a thorough induction on commencing employment at the service. All new care staff were required to complete the Care Certificate. The certificate is a set of standards that health and social care workers are expected to adhere to in their daily working life. They were also required to read and understand key policies and procedures, orientate themselves to the building and they were subject to a six month probation period with regular reviews and observation of practice. There was an employee handbook with further guidance and information for staff.

Training was on-going and this included mandatory refresher courses and extra training, such as stoma care, safe swallow, end of life care and falls prevention. Staff regularly attended the dementia 'jewels' training which uses different jewel names, such as diamond and pearl, to categorize the stages of dementia and highlight the best ways to assist people who are living with dementia. There was a system in place which generated a reminder when training was due. One of the care supervisors was a training champion. All staff were able to access corporate e learning courses via a unique log in to the system. Staff we spoke with felt there were ample opportunities for training.

Staff supervisions and observations of practice were undertaken on a regular basis. These were conducted using a focussed robust template formulated by the provider. This gave staff an opportunity to identify any concerns or training needs. The observations also helped supervisors identify practice issues, and feedback praise for good practice. Performance development reviews (PDRs) were undertaken annually so that staff could reflect on the previous year and look at training and development needs for the coming year.

Care plans included a range of health and personal information. Each care plan included a current skills plan with pictorial representations, to cover all aspects of daily living. There was a nutritional screening tool and a dietary care plan where required. People's food and fluid intake was monitored closely for the first few days and food and fluid charts were completed for those who required further monitoring. Weights were

recorded and monitored where necessary. We saw appropriate referrals to other services, such as Speech and Language Therapy Team (SALT) within the care plans.

We observed a multi-disciplinary meeting (MDT) where discussions centred on the people on discharge to assess beds. Individuals' general well-being, medicines, mobility, discharge plans and on-going services when discharged back into the community were discussed at length. This helped ensure people's on-going health needs were met.

We saw the menus which were prepared on a rotating four weekly basis. There were a variety of meals and alternatives given at each meal. We observed some of the lunchtime meal in both dining rooms. Lunchtime was a relaxing, pleasant experience, tables were nicely set and there was appropriate background music playing. People were assisted to sit where they wanted to and were given clothes protectors if they wanted them. Staff offered choices to each person, were patient and kind when assisting people and did not rush anyone. Tea and coffee was served in cups and saucers and staff wiped people's faces and hands throughout the meal to preserve their dignity. We saw they observed amounts people were eating and offered extra food and drinks. One person we spoke to told us, "The food is nice, oh yes". Others agreed.

Literature produced by the service, such as the welcome leaflet, could be produced in a range of different languages. It could also be created in large print and braille. This helped the information be accessible to a wider range of people.

We looked around the premises which had good signage to help people orientate around the home. People's bedrooms were fitted with dementia friendly furniture, that is drawers and wardrobes with transparent fronts which help people living with dementia to identify what is inside and that these are there belongings.

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 so that they can 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. We saw consent forms, which included information about people's level of capacity, within the care plans we looked at. These were for the use of photographs, information sharing and medicines administration and had been signed appropriately by the person who used the service or their representative.

Good

Is the service caring?

Our findings

One person who used the service said, "You can't fault them [staff]. I'm not criticising but I want to go home". Another told us, "We are looked after. There are no problems". A professional visitor we spoke with told us, "Staff are lovely and helpful. They don't know what time we are coming in but are always caring and assist us if we need them to". Another professional who was part of the multi-agency team told us, "I have always been impressed by the care supervisors in particular. They know the residents very well and always know where people are. I am amazed at their ability to calm people down. It is nice to see theory to practice". A health care professional we contacted said, "The staff are always friendly and go above the 'normal' routine to provide excellent care for everyone staying there whether it be for a few days or a few weeks".

An initial assessment was carried out for all those who were considering a period of respite. The service also undertook a carer's assessment, if required, for the person caring for the individual on a day to day basis. This allowed them to signpost the carer to support services to assist them in their caring role and help prevent carer breakdown.

Throughout the day we witnessed staff interacting with kindness, patience and respect with people who used the service. We saw examples of extreme patience when medicines were being administered and meals were being served. One person required a great deal of encouragement to take their medicines, but the staff member persevered for a considerable length of time. This paid off, with the person eventually taking their medicine happily and willingly.

We saw that the staff demonstrated a commitment to preserving people's dignity. For example, one staff member wiped a person's nose several times in a discreet and respectful way. Care staff had observations of practice on a regular basis to help ensure they were continuing to treat people with respect and to monitor how they communicated with people on a day to day basis.

An hourly 'comfort' rounding tool had recently been implemented. Staff asked each individual whether they were comfortable, needed the toilet or wanted a drink and recorded this. They also documented whether the person was asleep, had a visitor or had gone out. This helped ensure regular staff engagement with people and that each individual was comfortable at all times.

People who used the service and their relatives, where appropriate, were involved in the planning of their care and support. This involvement was documented in their care files.

There was a welcome leaflet which included an invitation to look around the home prior to the person's stay. It also outlined what to bring, GP and health care arrangements, a request to complete the care passport with essential information in case of admission to hospital, transport arrangements, information about visitors and meal times, admissions and discharges, duration of stay and some information about Deprivation of Liberty Safeguards (DoLS) for those who may be subject to an authorisation.

There was a confidentiality policy which was appropriate and up to date. People's records were stored

securely and staff were aware of the importance of keeping people's information safe. The service had a commitment to equality and diversity and there was a policy around this area. We spoke with the registered manager about how people's diverse needs and beliefs were respected and she explained in detail how the service endeavoured to be inclusive and ensure people were supported to follow their beliefs and interests.

Good

Is the service responsive?

Our findings

The care plans we looked were person centred and included information about people's strengths and abilities as well as the support they required. Their preferences and choices were documented within the files. A health care professional commented, "The staff ensure that the service is responsive to need and have effectively cared for many patients on my caseload".

There was an indication on people's bedroom doors whether they preferred a male or female carer, to help ensure they were cared for according to their wishes. We saw that people had choices in their daily routine. One person stayed in bed very late and staff checked on them at regular intervals. When they got up they were offered something to eat and drink immediately.

We saw evidence of activities occurring during the day. These activities were facilitated by staff from another Bolton Council service, volunteers from Age UK and staff at the home. We saw photographs of various activities that had occurred, for example, the service had been visited by Zoolab, where exotic animals were brought for people to look at and touch. Other celebrations included Christmas parties, entertainment and sing-a-longs.

The Customer Voice newsletter provided staff across the Bolton Council services with quarterly information. Compliments and complaints received by the department were outlined and this facilitated learning within the services. There were also thanks included in the newsletter for staff who had been complimented for their work.

There was an appropriate complaints system, where any concerns or complaints were logged and follow up actions documented. Questionnaires were given to all users of the service and their families to complete on discharge. The information from these was also used to drive improvement to the service delivery.

We saw a number of thank you cards and compliments received by the service. Comments included; "Many thanks for your care and help over the last couple of weeks during my stay"; "Many thanks for looking after our [relative] in your care home. The best hotel in town"; "Thanks to all the wonderful staff who looked after our [relative] so well".

There was an end of life champion amongst the staff at the home, who took the lead on this area. A number of staff had undertaken training in end of life care and the service worked closely with other agencies, such as district nurses, to help ensure people who were nearing the end of their lives were cared for appropriately and according to their wishes.

Good

Is the service well-led?

Our findings

The service had a manager in place who was registered with the Care Quality Commission (CQC) and was qualified to undertake the role. The registered manager was very knowledgeable about the people living at the service. They were supported in the day to day running of the home by the care supervisors and the multi-disciplinary team.

The registered manager had enrolled on an MSc dementia course which she felt, when completed, would assist enhance the service user experience. The registered manager felt that learning from the initial module, Dementia and the Enabling Environment, had helped with the recent refurbishment of the premises by including colours, contrasts and signage which was dementia friendly. She had also signed up to 'My Home Life' which is a nationally recognised organisation specialising in support for care homes. The programme provides an opportunity to learn from peer registered managers and had equipped her with additional skills and tools for managing effectively.

Staff told us they felt supported by management at the home. One staff member said, "I feel I could go to management if I needed to". Another told us, "I am well supported in my role".

The service undertook multi-disciplinary working and on observing the MDT meeting on the day of the inspection, we saw the merits of working in this way to achieve the best outcomes for people who used the service. Each member of the MDT had a role and was able to add something to the meeting to help ensure people were receiving the best care and facilitate a fully coordinated discharge and follow up to individuals leaving the service.

Accidents and incidents were recorded and the log included details of the incident, the impact and outcome. Analysis was achieved via an electronic system and this enabled the service to look at any patterns or trends and learn from these to drive improvement to service delivery.

The home had links with the local school, whose pupils and staff came in regularly to entertain people who used the service. Wilfred Geere House had signed up to be part of the Care Home Excellence programme in Bolton, where all care homes are in partnership with the Council and the CCG to improve the quality of their care. This partnership had facilitated new learning, for example, the home had taken part in the Virtual Dementia Experience, a short insight to what it feels like to live with dementia using virtual reality. This provided the care staff with a deeper understanding of the challenges of living with dementia and helped them improve the care they delivered.

The home had also volunteered to participate in the Care Home Falls Collaborative, working with other care homes, the Clinical Commissioning Group (CCG) Foundation Trust, Service uses and Advancing Quality Alliance (AQuA), an NHS health and care quality improvement organisation. This was to look at ways of reducing the risk of falls and managing falls more effectively, piloting falls screening and management plans. This had proved successful and was to be shared with other care homes.

We saw minutes of staff meetings which took place on a regular basis at the home. Discussions included the new enhanced dementia care to be implemented, learning and improvements in all areas, general issues relating to people who used the service and staff, discussions around the CQC domains. Staff were involved in analysing what they thought they did well and what they thought could be done better and how this could be achieved. The learning involved staff, management and support from the provider's quality team if required. This change had occurred as a result of my learning from the 'My Home Life Programme', the thinking being that if staff were involved in changes they were more likely to succeed. The registered manager met with other managers of the 'in-house' services in Bolton to share ideas and initiatives.

We saw that there had been staff consultation around how the new rotas should be set up, that is lengths of shifts and how many weekends should be worked. Staff comments and suggestions had been taken on board to help ensure rotas were more flexible and better suited to staff.

The service had a quality assurance file which included a service improvement action plan which was on-going. Monthly quality accounts were overseen by the Quality Governance Board, at quarterly meetings, which the registered manager attended, to share good practice. Service information was scrutinised at these meetings to help ensure continual learning and improvement. We saw evidence of learning from incidents, and changes to practice to minimise further risk.

Senior management undertook 'Walk and Talk' around the home, to offer people who used the service the opportunity to raise any concerns or make suggestions for improvement to the service. We saw comments from a recent 'Walk and Talk' which included; "The care could not have been better for my [relative]"; "The service is excellent, staff are pleasant" and, "Staff are professional and caring".

A number of audits were undertaken by the registered manager and senior staff. These included medicines audits, environmental audits, falls analysis and cleaning checks. We saw that issues were identified and actions recorded appropriately.