East Riding of Yorkshire Council

Wold Haven

Inspection report

Wold haven
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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

Overall summary

The inspection took place on 26 March 2015 and was unannounced. The last inspection was on 6 May 2013 when the service met all of the relevant requirements.

Wold Haven is registered to provide care and support for up to 43 older people in the market town of Pocklington in East Yorkshire. The service has two units with accommodation and other facilities provided on the ground floor. One unit has 37 bedrooms and the second is a six bedded re-ablement unit with facilities for short term care for people who need support to return home or to prevent an admission to hospital or respite care. There is also a courtyard and large garden.

At the time of the inspection there was a person registered with the CQC as the manager of the service. However, we were told that the person had recently left the home and there was a new manager in post who was in the process of applying to be the registered manager. They had commenced in their role the week of the inspection. A registered manager is a person who has

Summary of findings

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.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. The majority of staff had completed training on the MCA and discussions indicated that there was a clear understanding of the principles of the MCA and DoLS.

People told us they felt safe living in the home. We found people were supported to reduce risks in their lives through risk assessments and staff were knowledgeable about people's needs.

People were supported by staff who were correctly recruited, although not everyone felt there were enough staff. Staff received training and supervision to help make sure they could adequately support people.

People were supported by staff who were caring, polite and compassionate. People felt staff respected their privacy.

People were supported to have their needs met through a system of care planning. Not everyone could remember being consulted about this.

People received support to help make sure their dietary and health needs were met. This included when necessary accessing other health professionals.

People had given written consent to receive support when having their medication needs met in the home.

The manager was new in post but knew the home well. The service worked with other professionals to develop areas of support for people.

There were quality assurance systems in the home to help make sure people were consulted. However, not everyone could recall being asked their opinion of the home.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe .

People felt safe living in the home. Systems were in place to help keep people safe and minimise risks.

Staff were correctly recruited to work with vulnerable people. Not everyone felt there were adequate numbers of staff.

People received support to have their medication needs met.

Good

Is the service effective?
The service was effective.

People were supported to have their rights upheld.

Staff received training and supervision to help them in their roles when meeting people's needs.

People were supported to have their nutritional and health needs met.

Good

Is the service caring?
The service was caring.

People felt their privacy was respected. Staff were patient and polite, offering good support to people.

Staff knew people well and relationships were positive.

Good

Is the service responsive?
The service was responsive.

People were supported through a system of care planning to make sure their needs were known and met.

Systems were in place to enable people to raise concerns.

Good

Is the service well-led?
The service was well led.

Systems were in place to develop the service and respond to people's needs.

Staff felt the manager was approachable. Systems were in place to seek people's views although not everyone could recall this happening.

Quality assurance systems included audits and checks to help with the running of the home.

Good

Wold Haven

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.

This inspection took place on 26 March 2015 and was unannounced.

The inspection team comprised of one inspector and one 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. Their area of expertise was older person services.

Prior to the inspection we reviewed information we held about the service which included notifications from the service. The service had forwarded a provider information return (PIR) before our visit. This document recorded information about the service. After the inspection we received feedback from one health professional.

At the visit we spent time in communal areas of the home and observed daily practice. We also consulted with four people who lived in the home, talked to three staff and the manager. We reviewed three files for people who lived in the home, reviewed three staff files and looked at other records relating to the management of the home.

Good

Is the service safe?

Our findings

We asked people who lived in the home if they felt safe. They told us “Yes, the place is nice and safe, and staff here are lovely”, "Yes, there are good staff, my room is safe, the home is safe to move about", "Yes, there is always staff here, I can move around home safe", "Yes, there’s always someone around" and “I feel safe, staff are here all the time".

There were two folders kept within the home which included details of the safeguarding procedures to follow and information from latest best practice regarding safeguarding of vulnerable adults (SOVA). The home followed the local authority guidance on SOVA. When we spoke with staff they told us they had attended training on SOVA. They told us how they would refer any safeguarding concerns or allegations of harm to managers of the home. Staff training records and the staff training matrix held information which confirmed staff had attended training on the safeguarding of vulnerable people. This meant people were supported by staff who were confident in their actions should an allegation of harm be made.

People’s files included details of risk assessments which helped them to live their lives safely; these included the risks associated with any medical conditions, moving and handling, the risk of falls, the risks associated when getting dressed or undressed each day and the risks when bathing. Risk assessments and information were also in place to support people with any mental health needs which affected their behaviour. When we spoke with staff they clearly understood how to support the person with these needs. These meant that people could live their lives as they chose whilst risks of harm were minimised.

People also had ‘Personal Emergency Evacuation Plans’ (PEEP) which provided information on how they would be supported to leave the home should an emergency occur. This helped to make sure people’s assessed needs were considered and planned for should an emergency occur. The was also an emergency plan for if there was a ‘loss of services’ at the home. Again, this meant plans were in place to handle emergencies and to help make sure people’s needs would continue to be met.

There was a recruitment process in place which included undertaking checks to ensure potential staff were suitable to work with vulnerable people. Evidence of recruitment checks were recorded in staff files. This included Disclosure and Barring Service (DBS) checks which recorded if the person held a criminal conviction that would prevent them from working with vulnerable people.

We saw that staff provided evidence of their previous employment, qualifications and identity. One staff member confirmed they had followed the registered provider’s recruitment system. This included providing their personal details, references from previous employers and attending for an interview.

This meant staff were supported by people who had been recruited through a method of checking and verifying their skills and experience to ensure they could meet the needs of the people who lived in the home.

We asked people who lived in the home if they felt there were enough staff. We received a mixed response as people said, "The call button takes 3 to 4 minutes to answer, I have along wait in the morning", " I get a bath once a week, they don't have enough staff for anymore." In feedback the provider gave us evidence to show that people could chose when to have a bath.

Another person who lived in the home said, " Staff don't have time to talk to me, they are too busy", " Staff complain they are short staffed, but it doesn't affect me", " If I press the button staff come in a few minutes, but occasionally a 30 minute wait, quicker during the night." The provider also fedback the system for monitoring the response time to call bells. None of the examples given recorded a response time of 30 minutes, the majority of these were all responded to within five minutes.

Other people told us, " More than enough (staff), I never use the call bell button", " Seem to be enough, I never have to wait long" and "From my point of view yes." Additionally people felt there were always staff available to support them in particular if they needed urgent help.

When we spoke with staff not everyone felt there were adequate staffing levels. Staff told us how the needs of people living in the home had changed but that staffing levels had not changed in response to this. They gave an example that one person required two to one staffing but that this was not provided. Another staff member told us how there were not always the required amount of staff on duty. They told us this prevented them from having time to ‘chat’ with people. One staff member said “It is constant – non stop.”

Good

Is the service safe?

We observed there were a number of staff on duty throughout our visit. This included care staff, catering, domestic, laundry and administration staff. The manager told us how in addition to care staff, the catering and domestic staff worked in the home seven days a week to help ensure people's needs were met. When we looked at the duty rotas we saw there were between 6 and 7 care staff on duty each morning, between 4 and 5 care staff on duty each afternoon and three care staff on duty each night. This included senior and care staff.

People told us about the support they received with their medication. They said "I get them better here than I would do at home", "I get painkillers every now and again when I want one", "Lots of support and always on time" and "Yes, all medicines on time".

There were systems in place in the home to support people with their medication needs. There was a medication policy which provided information to staff on how to handle medication within the home. This included a system for the ordering, administration, storing and disposing of unwanted medication. This provided staff with information on how to correctly handle medication to help make sure people received the correct support.

We saw people had individual medication records which included staff signatures for when medication had been administered. We saw minor gaps on one of these records and the member of staff explained they had concentrated on ensuring the person's needs were met and not on the paperwork involved. This meant there was a risk that medication records may not be signed, accurate and up to date.

Peoples care files included information in relation to their medication. This included instructions regarding any topical medication or creams, for example, where these were to be applied. Additionally people had signed to give their consent to staff administering their medication on their behalf.

We checked some of the medication held within the home with the recorded amounts and found these to be correct. People were also supported with any medication which was described as Controlled' or 'CD's' this included painkillers.

Temperatures were taken of the 'medication' fridge and for the room medication was to be stored in. These were taken so the registered provider could ensure that medication was stored at the correct temperature and were not compromised. The temperatures of the room were only taken first thing in a morning and we discussed this with the member of staff. They agreed it would be good practice to vary the time for taking the temperature. This would help ensure a check of the temperatures throughout the day.

The manager undertook a regular audit of the medication system to help make sure there were no identified errors and the system was working effectively. This helped to make sure systems in the home were effective and people received their medication correctly.

Good

Is the service effective?

Our findings

People told us they didn't have restrictions in their lives, one person said they would like to go out more but other people said, "No, I go out occasionally", "Can't think of any, it's just like being at home", and "No restrictions told to me".

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. The manager told us how two people who lived in the home were subject to a DoLS restriction in their lives. Staff training records included that staff had received training in relation to MCA. In discussions staff reflected a good knowledge on MCA. This meant people were supported by staff who were trained and knowledgeable on how to protect people's rights.

People who lived in the home told us they felt staff were skilled in their roles. Comments we received included, "Yes, I don't have any problems with staff, fine with me" and "I would say they know their stuff", "General attitude and the way they behave is good, they know me", "Very good, they know their stuff", and "I would say so, I expect they are trained enough".

The staff training matrix and individual staff files included evidence that staff had completed a variety of training to enable them to effectively support people. This included for example, first aid, moving and handling of people, fire, food hygiene and dementia care. This helped to make sure people received the right support from trained staff. Staff told us they had completed training in fire safety and medication.

Staff also confirmed to us they received regular support though supervision sessions held in the home. We saw records of supervisions, 'EDR' s and annual appraisals. These sessions covered a variety of areas to help support the person with their role. This meant people were supported by staff who had support and guidance in their role, in turn helping them to provide the correct support in the meeting of people's needs.

We asked people about the meeting of their nutritional needs when living in the home. People told us, "The food is fine, no problem, there is a choice at lunchtime, and mainly sandwiches at teatime", "Not bad, always hot, a menu is on the table and I get a choice", "Staff know what I like and I can ask for a biscuit when I want one", "Food is good, you get too much really" and "Very good, good choice".

We saw that people could choose to eat either in their rooms or in the dining room of the home. We observed the dining room was well lit and tables were set with fresh flowers. This helped make a pleasant environment for people. One person was supported to have lunch in a quieter area of the home with their visitor and this helped support this relationship.

Staff knew the dietary needs and preferences for people who lived in the home. One member of staff told us how one person required a 'softer' diet, one person required a gluten free diet and some people required a diet to help them manage their diabetes. This helped to make sure people's dietary needs were met.

People's files included a universal malnutrition risk assessment or MUST assessment. This identified any needs the person had in relation to their dietary needs. We saw records of one person receiving support from a dietician. When necessary people's food and fluid intake was recorded and monitored. People's likes and dislikes in relation to food and drink were also clearly recorded. This meant people's preference regarding their diet was known and when necessary they received additional support to help ensure these needs were met.

We observed staff were patient when they supported people with their lunch, people were relaxed and the conversation was friendly. People were offered choices of drinks. Menus recorded a choice of two main meals or a lighter option.

We saw that adapted cutlery was available to people to help them remain independent when eating their meals. People's dignity was supported as people were offered the option of wearing a clothes protector to help protect their clothes from any spillages.

People told us about their access to health care. Comments included, "I did have access to a physio but not at all now" adding that they would like to get more help. "I have seen an optician here, not seen a dentist but should do", "No, never seen a dentist, but I have false teeth" and "I see an eye specialist at the Hospital once a month and my son takes me", "The district Nurse comes every day to give me my insulin injection and they are always on time" and

Good

Is the service effective?

"The district Nurse comes every other day to see me". People living in the home also said they had seen a chiropodist and optician. People did confirm that medical attention was sought if they were unwell.

One health care professional told us that staff were always available for discussion and followed their requests.

People's files included information in relation to any health needs which included details of multi agency assessments,

We saw records were kept for the monitoring of health needs and people had regular access to health professionals for example, the district nurse or GP. People also had patient passports. These record a summary of the person's main needs and are shared with health professionals if the person is admitted to hospital. This helped to ensure continuity of care as people's needs are known.

Good

Is the service caring?

Our findings

One person told us about the staff they said, "They are all very polite and treat you lovingly." Other comments included, "They'll do anything for you, and they talk to me", "They are kind, they all know my name", "They help me, and they are kind, they listen to me" and "They give time, and they help me if I need it".

When we talked with staff they reflected good knowledge of people's needs. They talked about people in a polite and caring manner. Staff could describe in detail the person's individual needs, the support they required and the person's preferences and choices.

We observed staff support both people in the home and relatives. Staff were caring, patient and compassionate with people. They clearly had good relationships with people and valued the people they were supporting.

Whilst we were on the inspection we were told how one person was unwell. The person's relative was visiting them and at one point the relative required additional support to help them with the situation. We observed staff were very responsive to this person's needs, they were calm and caring. They gave compassionate support to this person at a difficult time. This meant that staff had a holistic approach to the person's care and considered people who were important to them as well as their individual needs.

Not everyone who lived in the home was aware of their care plan and we received mixed responses as to how people were consulted about their care. Comments included "I don't know, never asked", "Yes, if you ask", "Yes I make my own decisions", "They tell me what things are for". and "Yes they do". However, we did not receive any concerns about the care provided and overall people were happy with the support provided.

We asked people if they were supported to maintain their independence. People told us "I don't feel that, I have asked if I can go out but they've said no", "Very much so", "Staff are here to help me", "Yes, I can dress / undress myself, but staff are here to help" and "If I need any help I just ask". We observed people were able to spend time in their rooms or in the communal areas of the home. For example, some people ate their lunch in their own rooms.

People told us staff respected them and their privacy. "Nine out of 10 times staff knock", "They always knock, they are nice to me" and "They respect me". Everyone confirmed they received their mail unopened and they could see or call their relatives in private. During the visit we noticed staff made sure bathroom, bedroom and toilet doors were closed appropriately to help resect people's privacy.

One professional told us, "Care is being carried out in a way which promotes dignity and confidentiality. Staff treat people with respect and kindness."

Staff told us they supported people to maintain their privacy and dignity. They told us how they made sure doors were closed and curtains were drawn when people were receiving personal care. One staff member told us how they asked people about personal support discreetly – maintaining their dignity.

Good

Is the service responsive?

Our findings

People had individual care files which included a care plan developed from their initial assessment of need. This described the individual needs of the person and the support they required with the meeting of these needs. We saw these records were regularly reviewed and updated.

Care files included care plans which identified each person's individual needs. Examples of identified needs included any needs with sight, hearing, mobility, continence, foot care and medication. The care plans included long and short term goals to help support the individual with the meeting of these needs.

Information also recorded the person's likes and dislikes, for example, the times the person liked to get up and to go to bed or that the person preferred a shower to a bath.

Each care file included a care summary sheet which described the care given to the person each day. In addition there was an individual daily diary which recorded some of the person's day, for example, the personal care given to the person. Staff told us how a 'handover' was undertaken between shifts to make sure that changes to the persons needs were shared. This helped to make sure all staff were aware of the persons latest needs and how these were to be met.

We saw records included details of any contact people had with their family and some of the activities they participated in, for example, 'complete a jigsaw'.

People told us they were able to watch TV, that their friends and relatives visited them and that there had been a visit from a minister at the catholic church.

We observed there was an 'activities' board on display in the home. This recorded only one activity that week which was bingo. We were told in feedback that an exercise class took place during the visit although we did not observe this. We were told there was no-one employed to undertake activities in the home and that 'Carers arrange activities when possible.' In feedback we were provided with evidence of activities undertaken by people who lived in the home. This included people going out on trips in their local community and weekly activity plans. These recorded that for the dates after the inspection there were opportunities to attend a Tulip activity and remembrance activities for VE day.

Life story work sections of the care plans were not completed. The manager told us how they had commenced this work and were waiting on information back from people's families to help them develop this work. Life story work provides information on the person before they moved into the home, for example, if they had a career or if they were married. This information helps staff to know the person and develop a relationship with them.

We asked people who lived in the home about making complaints. They told us "I would see my keyworker, I feel comfortable talking to her", "I have never had to complain and I don't know the complaints policy", "I would see the chief, I have never seen her though", "I would see the carer that looks after me, or Head Carer" and "I have never had a complaint - I love it here".

Staff told us people who lived in the home were open in their conversations with staff and would readily tell them any concerns or complaints they had. The manager told us they had not received any complaints.

We saw that forms for raising both compliments and complaints were available in the entrance hall of the home. The complaints policy was available as part of the service user's guide to the home.

Good

Is the service well-led?

Our findings

At the time of the visit there was a registered manager in post. This person was not on site on the day of the visit and a new manager had recently been employed to take over this role. They told us they had commenced their application to register with CQC.

People told us there was a “Nice atmosphere here, I could talk to manager", "It is very free and easy, that's what I like about it", "I wouldn’t have stayed here if there wasn’t (a nice atmosphere)" and "Nice pleasant place, I suppose you can talk to Manager". Although one person was not sure who the manager was. Staff also told us they felt the manager was approachable.

The manager told us about the innovative work they were undertaking with local GP practices. This was to provide additional support and to help prevent hospital admissions when a short stay in the home could meet the person’s needs. For example, when someone had suffered a short illness and needed additional support on a temporary measure. This also involved other professionals and meant collaborative working with the home.

When we talked with the manager they discussed how they accessed other professional organisations for example, the Social Care Institute for Excellence to help make sure they remained up to date with latest best practice.

We reviewed the quality assurance system within the home. The systems included a plan for auditing throughout the year and involved the use of questionnaires to establish people’s views about the home. Questionnaires were sent to people who lived in the home, staff, relatives and stakeholders. When these forms were received back pie charts were completed to summarise this information and feedback the results. The manager told us how they fedback the results to people who lived in the home at the ‘residents’ meetings. However, none of the people we spoke with could recall completing surveys or receiving this feedback.

We saw the quality assurance system included audits of different aspects of the home, for example, there were audits of the care plans and spot check audits of the medication systems. Additionally there was a checklist to ensure forms were in place, weekly fire equipment checks, records of all cleaning undertaken in the home, and records of checks of the temperature of the hot water in the home. These checks helped to make sure the environment remained safe to people who lived in the home. Additionally we saw there was a system for reporting any repairs which required completing to the maintenance person employed in the home.

We were told by the manger that records of falls were monitored and when necessary people were referred for additional professional support with this. We saw how one person had been referred to the ‘falls’ team to assist them with this. Additionally records were kept of all accidents or incidents in the home.

We saw that meetings were held for both people who lived in the home and for staff. These enabled people to remain up to date about issues within the home. However, the manager told us there were difficulties in getting ‘people to attend’ staff meetings. We were told in feedback that changes had been made to ensure all staff attended meetings and staff seminars were held to address this. One person who lived in the home told us they attended the residents meetings.