Maria Mallaband 15 Limited

Wyndham Hall Care Home

Inspection report

Skimmingdish Lane
Launton
Bicester
Oxfordshire
OX26 5AF

Tel: 01869722767

Date of inspection visit:
28 April 2016

Date of publication:
16 May 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

This inspection took place on 28 April 2016. It was an unannounced inspection.

Wyndham Hall is a new service registered in August 2015 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 20 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.

We were greeted warmly by staff at the service who seemed genuinely pleased to see us. The registered manager checked our identity before allowing us to proceed with the inspection. The atmosphere was open and friendly.

Relatives told us people 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 high quality care that was personalised and met their needs.

Where risks to people had been identified risk assessments were in place and action had been taken to reduce 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. Staffing levels were consistently maintained. The service had robust recruitment procedures and conducted background checks to ensure staff were suitable for their role.

Staff understood the Mental Capacity Act (MCA) and all staff applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves. The registered manager was knowledgeable about the MCA and how to ensure the rights of people who lacked capacity were protected, this included Deprivation of Liberty Safeguards (DoLs).

The service had systems to assess the quality of the service provided. Learning needs were identified and action taken to make improvements which promoted people's safety and quality of life. Systems were in place that ensured people were protected against the risks of unsafe or inappropriate care.

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

People and their relatives told us the service was friendly, responsive and well managed. People knew the registered manager and staff and spoke positively about them. The service sought people's views and opinions and acted upon them.

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 risk and keep people safe. People received their medicine as prescribed.

Is the service effective?

Good

The service was effective. 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.

Staff had been trained in the Mental Capacity Act (MCA) and understood and applied its principles.

Is the service caring?

Good

The service was caring. Staff were 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. People were involved in their care.

The service promoted people's independence.

Is the service responsive?

Good

The service was responsive. Care plans were personalised and gave clear guidance for staff on how to support people.

People knew how to raise concerns and were confident action would be taken.

People's needs were assessed prior to receiving any care to make

sure their needs could be met.

Is the service well-led?

Good

The service was well led.

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

People knew the registered manager and spoke to them with confidence.

There was a whistle blowing policy in place that was available to staff around the service. Staff knew how to raise concerns.

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 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 the 28 April 2016. It was an unannounced inspection. This 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 seven people, two relatives, five care staff, a nurse, the chef and the registered manager. We also spoke with a visiting healthcare professional. We looked at five people's care records 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 captures 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.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR and notifications we had received. A notification is information about important events which the provider is required to tell us about in law.

Good

Is the service safe?

Our findings

The majority of people living at the home were living with dementia and could not speak with us. Those we did speak with told us they felt safe. One person said, "Yes I am safe here". Another person said "Perfectly safe". Relatives we spoke with told us people were safe. One relative said, "I have no concerns on that score, this is a safe place".

People were supported by staff who could explain how they would recognise and report abuse. They told us they would report concerns immediately to the registered manager. Staff were also aware they could report externally if needed. Staff comments included; "I have had the safeguarding training and I know what to do. If I saw anything that concerned me I would report it to the manager and CQC (Care Quality Commission). I can also call the local authorities", "People can withdraw and become tearful when abused. I can report to my manager if I am worried", "I can whistle blow to the head of the organisation or CQC", "I know the residents well and can tell when something is off" and "I can report to the safeguarding team or social services". Records confirmed the service had systems in place to report any concerns to the appropriate authorities.

Risks to people were managed and reviewed. Where people were identified as being at risk, assessments were in place and action had been taken to manage the risks. For example, one person was at risk of falls. The person had stated they would 'like to achieve mobility with supervision and minimal assistance'. The risk assessment gave staff guidance on how to keep this person safe whilst respecting their wishes. This guidance included using 'safe moving and handling procedures' and ensuring the person was wearing 'appropriate foot wear'. We saw this person walking independently and they were wearing appropriate footwear. Staff were in attendance, supervising the person but with minimal support.

Another person was at risk of pulling out their urinary catheter and stoma bag. Risk assessments had been completed to ensure their safety. The assessment stated the person was to hold a stress ball as distraction to manage the risk. We saw this person holding the stress ball. Staff were guided to check regularly on this person and ensure they were holding the stress ball. Records and staff confirmed these checks were carried out. Other risks managed included pressure care and risks associated with people's medical conditions.

Staff told us there were sufficient staff to support people. Comments included; "There's enough staff here and I know as our resident numbers increase the manager wants to increase staff as well", "I think we have enough staff and are still recruiting" and "We definitely have enough staff at the moment".

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. People were assisted promptly when they called for help using the call bell. Staff rota's confirmed planned staffing levels were consistently maintained.

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.

People had their medicines as prescribed. We observed a medicines round and saw staff checked each person's identity and explained the process before giving people their medicine. People on required medicines had a PRN protocol for each medicine. Medicines were stored securely and in line with manufacturer's guidance. Records for administering medicines and stock levels were accurately recorded and regularly checked. Staff were trained to administer medicine and their competency was regularly checked by the registered manager.

People had personal emergency evacuation plans to ensure their safety during emergencies. Risk factors were identified which included mobility, hearing, eyesight and mental capacity in relation to understanding the layout of the building. Plans to guide members of staff on how to support people during evacuations were clearly documented in the care plans.

People's safety was maintained through the maintenance and monitoring of systems and equipment. During our inspection a fire alarm test was conducted. We established that equipment checks, water testing, fire equipment testing, hoist/lift servicing, electrical and gas certification was monitored by the maintenance staff and carried out by certified external contractors. We saw equipment was in service date and clearly labelled.

Good

Is the service effective?

Our findings

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. Induction training was linked to the 'care certificate', a nationally recognised qualification, and included fire, moving and handling and infection control. Staff comments included; "I found the training really good as I am new to this role. It gave me confidence to work", "I had two days shadowing but now they have two weeks at least", "I had lots of training during induction and I am still learning" and "I had a really good induction which prepared me for my role".

Staff told us, and records confirmed they had effective support. Staff received regular supervision, a one to one meeting with their line manager. Supervisions and appraisals were scheduled throughout the year. Staff were able to raise issues and make suggestions at supervision meetings. For example, one member of staff said, "I've had supervisions and I think I get good support. Everything I have asked for I've got". Staff were also supported to develop professionally. Five members of staff had signed up to the 'health and social care diploma' in dementia and another member of staff had achieved a level two in care in a national qualification.

We discussed the Mental Capacity Act (MCA) 2005 with the registered manager who was very knowledgeable regarding the Act. 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 were supported by staff who had been trained in the MCA and applied it's principles in their work. Staff offered people choices and gave them time to decide before respecting their decisions. Staff spoke with us about the MCA and demonstrated a good understanding of the Aact. Staff comments included; "I've had this training and working with people with dementia is all about individuals. It's about supporting their choices and working in their best interests. I give them time to decide and try to persuade them if they make a bad decision but it is about their decisions", "MCA is about making good decisions for those who can't" and "We assess people who cannot make decisions for themselves. I have also involved the mental health team".

People's capacity to make decisions was assessed and recorded. For example, one person was having difficulty deciding what clothes to wear and could dress inappropriately. The assessment concluded the person was unable to 'use or weigh information' as part of the decision making process. Further assessment was required and the person had been referred to mental health specialists. The care plan had been amended to reflect the assessment and guided staff to 'give the person time' with decisions and to use 'simple words' to support their cognitive function. Another person did not have capacity and had a relative who had been appointed lasting power of attorney (LPA). This meant they could legally make decisions relating to the person's care and welfare on their behalf. We saw this person's relative had been actively

involved in the person's care planning.

At the time of our visit no one was subject to a Deprivation of Liberty Safeguards (DoLS) authorisation. These safeguards protect the rights of people by ensuring that if there are any restrictions to their freedom and liberty these have been authorised by the supervisory body. The registered manager told us they continually assess people in relation to people's rights and DoLS and understood the court of protection was the decision maker in this process. The registered manager told us, "Where we have identified issues with people's capacity with certain decisions we have applied for DoLS authorisations".

Staff demonstrated a good understanding about how to ensure people were able to consent to care tasks and make choices and decisions about their care. Throughout our visit we saw staff offered people choices, giving them time to make a preference and respecting their choice. For example, at the lunchtime meal we saw people's preferences regarding food and drink were respected. We spoke with staff about consent. One staff member said, "I never do anything until I've got their consent. Even if they cannot speak I recognise their body language and this lets me know". Another staff member said, "I always ask residents if they are okay having either a male or female carer".

People received effective care. One person was at risk of pressure ulcers. Guidance was provided for staff which included regular monitoring of the person's skin and applying prescribed creams to manage the risk. Daily notes evidenced this guidance was being followed. The person did not have a pressure ulcer.

People were supported to maintain good health. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included the GPs, speech and language therapist (SALT) and the physiotherapist. Visits by healthcare professionals, assessments and referrals were all recorded in people's care plans. One healthcare professional we spoke with said, "I think this is a good home. I get appropriate referrals and they do follow any guidance".

People told us they enjoyed the food. People's comments included; "The food here is good", "I love the food. I can ask for anything" and "The food is great". However one person said, "When I was first here there used to be two staff looking after me so well at meal times but now it all takes a little longer to be served and I have to wait for my food as the ladies get theirs first". We observed the lunchtime meal and did not see any delays in people being served their meals.

The midday meal experience 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. The meal was a friendly and communal experience. We spoke with the chef who told us he "Loves it here". He went on to say, "I appreciate the resident's needs and I've made sensory changes such as the smell of food being apparent at meal times". The chef attended the midday meal and spoke openly with people who responded with smiles and comments that demonstrated the chef was familiar to people.

Staff assisted people with their meal choices and where people required support with eating, this was given discretely and appropriately. One person decided they did not want their meal choice and asked the chef for an omelette. This was immediately provided. One member of staff told us how they supported people to eat and drink. They said, "I always sit with them and ask how they would like to be helped. I help them as they want and at their pace, I don't rush them". Another staff member told us how they monitored people's weight. They said, "We record on food and fluid charts to make sure residents have enough food and drink. We communicate with the chef and monitor weights for those losing weight".

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 were extremely positive with their praise for staff. Comments included; "A lovely lot of carers. I have a favourite who helped me when I arrived. I can't fault them", "I think the staff are exceptional" and "It is very good and comforting to be able to come back here". One relative we spoke with told us they chose Wyndham after seeing other homes. They especially praised the manager and staff and said "It was no contest". The home had a key worker system. The key worker was the main point of contact for a person and their relatives for any matters relating to their care. This formed meaningful relationships between people their relatives and staff.

Staff told us they enjoyed working at the service. Comments included; "I love it here as I've always wanted a job where I can give something back" and "We have caring relationships here. I treat our residents as family".

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, family and where they had lived. During our visit we saw numerous positive interactions between people and staff. For example, one person approached the registered manager and was clearly upset. The registered manager put their arm around the person and asked what was wrong. The person indicated they wanted to return to their room and the registered manager took them back and arranged for a member of staff to sit with them. The person responded to the registered managers words and became less anxious.

People's independence was promoted. For example, one person's care plan highlighted the person liked to shower as 'independently as possible' and would 'communicate their needs and ask for assistance'. The care plan stated the person could wash their top half but 'needs assistance with back and lower part' of their body. A staff member told us, "I try to let them do as much as they can for themselves. It keeps them doing what they can do". Records evidenced this person was supported to remain independent.

People were involved in their care. People were involved in care reviews and information about their care was given to them. For example, one person was being wheeled in their wheelchair back to their room for personal care. The staff member was informing the person what need to be done and asked "Hair washed first or last, you choose". The person was fully involved in the process and made their choice. Care plans contained personal details, wishes and preferences stated by people evidencing their involvement in creating the care plans.

People's dignity and privacy were respected. We saw staff knocked on doors before entering people's rooms. Where they were providing personal care people's doors were closed and curtains drawn. This promoted their dignity. We saw how staff spoke to people with respect using the person's preferred name. When staff spoke about people to us or amongst themselves they were respectful. Language used in care plans was respectful.

We spoke with staff about promoting people's dignity and respecting their privacy. Comments included; "I

knock on doors before I enter resident's rooms and I close doors and curtains when providing personal care", "I cover them as much as I can with personal care and I'm polite. I don't make a fuss of things for them" and "I always cover residents with towels during personal care".

People were supported to plan for their end of life where they expressed a wish. These wishes were recorded in care plans with clear guidance for staff to follow. Where people did not want to discuss end of life wishes, this was recorded and the person's wish respected.

People's confidentiality was respected and maintained. Staff told us how they maintained confidentiality. Staff comments included; "We do not discuss residents in public" and "We have login passwords for e-records". We observed staff login in and out throughout the day and when staff left commuters they logged off maintaining security. People's paper records were kept secure in locked cupboards.

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. Care plans were detailed, personalised, and were reviewed regularly.

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 was living with dementia which had affected their memory. Staff were guided to use information from the person's 'life story' contained in the care plan to 'encourage stimulating conversation' with the person. Another person had stated 'I like two pillows, a top sheet and a blanket' on their bed. We went to this person's room and saw the bed made to their preference.

Care plans and risk assessments were reviewed to reflect people's changing needs. Staff completed other records that supported the delivery of care. For example, where people needed topical creams applied, a body map was in use to inform staff where the cream should be applied. Staff signed to show when they had applied the cream and there was a clear record of the support people received. Staff also completed weight charts, food and fluid charts and records relating to general health such as blood pressure. These were consistently maintained and up to date. Where people's needs changed, this was recorded in care plans. For example, one person's needs had changed as their condition improved and records showed that monitoring of a particular condition was 'no longer required'. Another person was observed by staff that they were not eating well. A referral was made to the speech and language therapy team (SALT) who assessed the person and advised for them to eat only soft foods. Records confirmed this guidance was being followed and the person was eating well again.

People received personalised care. For example, one person living with dementia did not react positively to the colour of their ensuite bathroom door. The service repainted the door a different colour which the person approved of. Another person living with dementia experienced difficulties at meal times because they struggled with similar colours which confused them. Staff were guided to use a dark coloured place mat and a light coloured plate to give the person a clear contrast so they could identify their plate and meal. We saw at the lunchtime meal this guidance was followed and the person was able to enjoy their meal.

People were supported by staff who understood, and were committed to delivering, personalised care. Staff explained to us how they tailored people's care to suit their personal preferences. One member of staff said, "Personalised care is treating residents as individuals. They have their own ways and routines. I try to find these out and work their way".

People were offered a range of activities including games, quizzes, sing a longs, arts and crafts, keep fit, and gardening. Hairdressers attended the home every week and people were encouraged to go out with families and friends or on their own where they were able. Church services were regularly provided for people to attend. The home had an arts and crafts room equipped with a range of materials for people to use such as

paints, brushes, pencils and colouring pads. There was also a 'grand children's' activity room equipped with toys, games and soft furnishings for children. This allowed grandchildren visiting people the opportunity to play without disrupting the family visit. The home also had large, well maintained garden areas for people to enjoy. Access to the garden was unrestricted and accessible for people who used wheelchairs. The registered manager told us, "As numbers of resident's increase we have planned trips out of the home and will use resident's preferences and histories to inform how we organise trips and activities".

The second floor of the home was a 'dementia unit'. The new building had been decorated to a high standard but was not dementia friendly. Signs on this floor were in small print and could be confusing to people. Some areas had wallpaper that could distract or confuse people living with dementia and corridors were all the same colour making it difficult for people to navigate. However, we saw that as people occupied their rooms alterations had been made to suit their needs. For example, different coloured toilet seats had been installed and suitable signs placed on people's doors. Dementia friendly furniture was in all the rooms providing easy access to wardrobes and drawers. Occupied rooms contained people's personal belongings, photographs and furnishings giving a homely feel. We asked the registered manager about the second floor décor. They said, "This is a work in progress. As it is a new building I am having to change things as we progress and décor is one of those things. My plan is to use best dementia practice to redecorate the second floor. I am also planning to install stimulating items and equipment such as hat stands with clothing, soft toys and interactive board's residents can engage with".

People and their relatives were provided with information about how to complain or raise issues. People were provided with a 'service user guide' when they entered the home. This contained the complaints policy and gave details on how to complain. The service had been operational since August 2015 and had received no complaints. The registered manager said, "We have been able to deal with any raised issues long before we reach the formal complaint stage. I make sure I keep in touch with all our residents and we have regular resident and relative meetings". We saw the minutes of resident and relatives meetings and confirmed people's opinions were sought and action taken to respond to issues raised. For example, people had raised the issue of IT related activities. We saw the service had purchased a variety of IT equipment for people and staff supported them in its use. We also saw the service planned to conduct regular 'resident's and relatives' surveys to further obtain people's views and opinions.

Good

Is the service well-led?

Our findings

We saw that people knew the registered manager. As we were given a tour around the home people stopped the registered manager to say hello. People spoke to her with familiarity and the registered manager responded with genuine warmth. One person stopped the registered manager to tell her a story and we saw both the person and registered manager laughing at the stories conclusion.

Staff told us they had confidence in the service and felt it was well managed. Comments included; "She is lovely, I can approach her with any problems. We have really good communications here", "The manager is brilliant, supportive, approachable and forth coming", "Manager is alright" and "Manager is very supportive especially that I'm new". The registered manager said, "I can't do this on my own. I have a great leadership and staff team to support me".

The service had a positive culture that was open and honest. Throughout our visit management and staff were keen to demonstrate their practices and gave unlimited access to documents and records. Both the registered manager and staff spoke openly and honestly about the service and the challenges they faced. Staff told us they felt the service was open and honest. One staff member said, "I believe we are an honest service. We have nothing to hide and I would happily own up to a mistake because they would support me". A visiting healthcare professional said, "I have to say I find the manager and staff here very good. Before arriving here some of my patients were quite anxious about the move but they have all settled really well".

The registered manager spoke with us about their vision for the service. They said, "Residents are the centre of what we do. I am not rushing to fill this home because I want to develop our facilities and what we do in line with resident's needs and wishes. I want to get things right".

Accidents and incidents were recorded and investigated. The results of investigations were analysed by the provider to look for patterns and trends. They were also analysed to see if people's care needed to be reviewed. For example, one person suffered a series of falls. The risk assessment was reviewed and care notes identified the person was more confused and had suffered a decline in their health. The person's care was reviewed and this included their cognitive function as this could affect their ability to mobilise. The review concluded the falls were a result of the person's declining condition and they were subsequently cared for in bed.

Learning from accidents and incidents was shared through staff meetings, handover meetings and the communications book which was used to record changes in people's condition, moods and care needs. This alerted staff to this information at shift change overs. One member of staff said, "Throughout our shifts we have 'flash meetings' where we raise concerns or issues and this learning is shared with the team. We also get informed of any changes to residents care plans".

Team meetings were regularly held where staff could raise concerns and discuss issues. For example, at one meeting the chef raised the issue of picture menus for people living with dementia. This was discussed and we saw action was being taken to provide people with picture menus. The registered manager said, "Every

day we have a head of department meeting in the morning for updates".

The registered manager monitored the quality of service provided. Regular audits were conducted to monitor and assess procedures and systems. Audits covered all aspects of care including safeguarding, infection control, health and safety and medicines. Action plans were created from audit results to improve the service. For example, following an infection control audit the registered manager appointed an 'infection control lead' member of staff, more training for staff relating to infection control, a review of external services used and a review of cleaning schedules. We saw one staff member cleaning an unoccupied room to a high standard. This staff member said, "I want it to look really good for people being shown round".

The provider conducted checks around the home twice a month to monitor the service. These visits generated action plans to improve the service. For example, one visit identified actions from an HR audit required completion. Records confirmed these actions had now been completed.

There was a whistle blowing policy in place that was available to staff across the service. 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, (the 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.