Grandcross Limited

The Wimborne Care Home

Inspection report

179-181 Wimborne Road West,
Wimborne, Dorset, BH21 2DJ
Tel: 01202 877614
Website: www.brighterkind.com/thewimbourne

Date of inspection visit: 5 and 6 October 2015
Date of publication: 02/12/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

At our last inspection in February 2015 we had concerns about the care and welfare of people, staffing, records and quality monitoring. There were breaches of regulations. We asked the provider to take action. Following the inspection the provider sent us an action plan. They told us they would meet the relevant legal requirements by July 2015.

At this inspection we found some improvements had been made. However further improvements were needed to some people's care plans to ensure they had detailed personalised information. Some did not provide sufficient detail about people's likes, dislikes and preferences. This meant there were inconsistencies and some people did not receive person centred care. The registered manager told us the service was in the process of changing the documentation and the process for ensuring information was updated.

During our inspection we saw evidence that people and their relatives were being involved in a review of their care plan and their choices and preferences were being updated. However this process had started in October 2015 and was on-going at the time of our visit. This meant at the time of our inspection some people did not have a personalised care plan however there was a plan to address this.

Summary of findings

Some improvements had been made to quality monitoring systems. However further improvements were needed to ensure all care records were checked and any gaps identified, to consistently ensure people received person centred care. People's care records included some observation charts which were kept in people's own rooms. They were a record of the checks people needed or if necessary a record of the food and drink they had received. They also included a repositioning chart, for people identified as at risk of skin damage. There was a twice daily check of observation charts by a registered nurse who signed to confirm the checks had been completed. Discrepancies were identified promptly and corrected.

Regular review of people's risk assessments and risk management plans were completed. People who needed regular checks or observations had them recorded as needed.

The provider was actively recruiting staff. The registered manager told us they were recruiting more staff than required in order to ensure there was always sufficient staff to cover staff absence. Staff told us staffing had improved and they felt there were sufficient numbers on duty. One health and social care professional told us they had visited the home at different times and there were enough staff to meet people's needs.

Staff told us the registered manager was approachable and supportive and that morale in the home was good. Staff spoke warmly about people and each other. Some staff and people described the home as "like a family." Staff told us they loved working in the home.

Staff told us training had improved and there were more opportunities for learning.

People had access to healthcare and staff responded to people when they showed signs of being unwell. Health and social care professionals told us that staff refer people appropriately and follow recommendations.

People were able to engage in a range of activities which were provided in either a group or individual basis.

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?

Good

People were protected from harm or abuse. Staff had received training and were able to describe to us how they would recognise cases of abuse and how they would report it.

People had their risks assessed and if a risk was identified there was a management plan and regular reviews took place.

People received their medicines safely. Medicines were stored correctly and at the right temperatures.

Is the service effective?

Good

People received care and support from suitably trained and experienced staff.

Staff received regular supervision and there was a system for ensuring all staff received an annual appraisal.

Staff understood the principles of the Mental Capacity Act (2005) and how it applied to their work.

New staff had an induction and there was a system for ensuring new staff did not work unsupervised until the registered manager was confident they were competent to do so.

People received sufficient food and drink. People who had specific dietary requirements had their needs met.

Is the service caring?

Good

People were cared for by staff who were respectful, patient and kind.

People had their privacy and dignity respected.

People were involved in decisions about their care.

Is the service responsive?

Requires improvement

People who lacked verbal communication skills did not have sufficient personalised details in their care records. This meant people did not consistently receive person centred care.

The registered manager had commenced a new system for reviewing care needs. People and their families were invited to a monthly review of individuals care plans.

People and their relatives told us they were listened to. There were systems for feedback and the provider been proactive in taking actions.

Summary of findings

Is the service well-led?

Quality monitoring systems were not sufficient to identify when people did not have a personalised care plan.

People and staff had confidence in the registered manager.

Staff knew what was expected of them and were happy and motivated in their work. They felt listened to and valued by the registered manager.

Requires improvement

The Wimborne 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 5 and 6 September 2015 and was unannounced. The inspection was carried out by one inspector who was accompanied by a second inspector on day two.

Before our inspection we reviewed information we held about the service including notifications of incidents and the action plan that the provider had sent us after our previous inspection. A notification is the way providers tell us important information that affects the care people receive. At the time of the inspection a Provider Information Record (PIR) had not been requested. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information during the inspection and spoke with the manager about this.

During our inspection we looked around the home and observed how staff interacted with people and each other. In order to gain more information about the service we spoke with seven people, and two people's relatives. We also spoke with the registered manager, regional manager and seven members of staff. We looked at five people's care records and observation charts. We also looked at samples of the Medicine Administration Record's (MAR) and staff records. We saw four weeks of the staffing rota, the staff training records and other information about the management of the service.

We contacted a representative of the local authority's contract monitoring team and the care commissioning group involved in the care of people living at the home to obtain their views on the service. We spoke with two health and social care professionals.

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.

Good

Is the service safe?

Our findings

At our last inspection in February 2015 we had concerns that the provider had not taken steps to ensure there were sufficient numbers of suitably qualified, skilled and experienced staff to meet people's needs. Risks to some individuals were not managed to keep them safe. Following the inspection the provider wrote to us and told us they would make improvements. During this inspection we found improvements had been made.

There were sufficient staff available to ensure people received safe care. There had been an increase in the number of qualified nurses working in the home and three registered nurses had been appointed since our last inspection. People's dependency levels were reviewed on a monthly basis, or sooner if needed. The registered manager reviewed staffing levels based on people's dependency levels and adapted the rota to ensure there were sufficient staff to meet people's needs. This was done at least monthly. This meant people received care from staff who knew them and was consistent.

People told us overall there were enough staff. One person told us the staff were "lovely and give me plenty of time." Staff told us there were enough staff and told us they had enough time to make sure people received the right care. The service was actively recruiting and the aim was to have more staff available to work than was needed so as to provide sufficient cover during staff absence, and to have a bank of staff to work as and when required. The core staff were five care workers during the day shift with two nurses in the morning and one in the afternoon. At night there was one nurse and two care workers. The duty rosters reflected this. The registered manager told us the numbers of staff could change if there was a change in dependency levels. For example the regional manager told us that they planned to increase care workers to three at night, based on increased dependency levels of some people during the night.

Recruitment of staff had been carried out safely. The service carried out checks on staff before they started work which included checks with the Disclosure and Barring Service, identity checks and obtaining references in relation to their previous employment. There were checks completed of nurse registration.

Medicines were stored safely and at the correct temperatures. All registered nurses were required to complete a competency assessment and additional training. There was a medicines policy and Medicine Administration Records (MAR) included a list of homely remedies which could be administered. The MAR also included an up to date photograph of the person which provided an additional safety measure to ensure the right person received their medication.

People were protected from abuse. People told us they felt safe living in the home and one person told us, "It's somewhere safe for me to be." Staff received safeguarding training as part of their induction prior to starting work in the home and were able to tell us about the types of abuse and what actions to take if they suspected abuse. There was a safeguarding policy and a multi-agency protocol available for staff. The registered manager had made an appropriate referral to the safeguarding team, for example a referral had been made following a medicine error. The member of staff was investigated and they had been dismissed. Health and social care professionals told us the registered manager had carried out all the correct procedures and they had completed any recommendations which had been made following the event. Staff were able to tell us about the whistleblowing procedures and how they would report poor practice.

People had their risks assessed. We saw there were a range of specific risk assessments, for example a moving and handling risk assessment and a nutritional risk assessment. Where some risks had been assessed we saw control measures had been put in place to mitigate the risk. An example of this was one person required equipment to support them with standing and walking. The risk assessment and management plan gave clear and specific guidance to staff about how much the person could do independently and what equipment and support was required. Another person had risks associated with choking. We saw the senior care worker was on hand during lunch to support a care worker as they assisted this person with their meal. A health and social care professional told us the staff followed recommendations they made to manage people's risks.

The service employed a maintenance person and there were regular checks of the environment and equipment to ensure they were safely maintained.

Good

Is the service effective?

Our findings

At our last inspection we found staff had not received regular supervision. As well as this we recommended the provider reviewed their systems for checking whether people's rights were upheld. During this inspection we found improvements had been made.

Staff received regular one to one supervision with a manager, in line with the supervision policy of four times a year. There was a record of each session which the supervisee kept a copy off. Group supervision was also organised based on a specific theme, for example in September 2015 there was a group supervision session about "resident's choice." Staff had either had an appraisal or were booked to have one by the end of October 2015.

Staff understood the principles of the Mental Capacity Act (2005) and how it applied to their work. People had their capacity to consent to care and treatment assessed. Those people who had capacity had signed their consent. There were some people who lacked capacity and appropriate applications for a Deprivation of Liberty Safeguards (DoLs) authorisation had been made to the local authority and were waiting for an assessment by the local authority.

When people lacked capacity we saw that decisions had been made in their best interests to carry out certain aspects of care and support which were needed. For example there was a best interest's decision for a person who could not consent to receiving support with personal care. Relatives had been involved in the decision making process. The clinical lead had introduced a new system for recording best interest's decisions and was in the process of completing it.

People received care from suitably trained and experienced staff. People and their relatives told us they have confidence in the staff and feel they have the right skills. The service had changed the training provider and some of the required training was via e-learning. Staff were given an incentive to complete the training and were entered into a raffle each time they completed a course. The regional manager was able to confirm the percentage of staff that had completed training had increased. The required training covered a range of subjects which included basic life support, equality and diversity, infection control, first aid and food safety. Some training was delivered face to face. For example, during our inspection staff received face to face training from the clinical facilitator on care documentation. Staff told us improvements had been made and they were offered more training now, for example one nurse had completed some training on tissue viability, a care worker had received training on assisting people who had swallowing difficulties.

New staff received an induction. They were allocated a mentor and had a workbook to complete. This included orientation to the home and covered essential information such as fire safety. Each new member of staff was required to familiarise themselves with people's care plans. They were given a handover sheet which contained information about each person and important information for example if they were on a special diet. There was a system for assessing the member of staff as competent which was agreed and countersigned by the registered manager.

People told us they enjoyed the food. One person told us "the food is good." The menu was planned in advance and there was a choice of two meals. Alternatives were available if requested. One person told us "the chef knows I'm fussy and will come and see me and ask me what I like." Another person told us they had a particular food preference, their family arranged for it to be bought in and the chef was happy to prepare it for the person at their request. The chef told us they visit people to enquire about food preferences to help with planning the menu.

People had access to healthcare for example during our inspection one person was unwell and the home arranged for a GP to attend. There were visits recorded in the care records from other health care professionals such as a stroke nurse, speech and language therapist and chiropodist. People told us staff "look after us well."

Good

Is the service caring?

Our findings

At our last inspection we observed some staff speaking in front of people in a disrespectful manner. During this inspection improvements had been made. Staff were respectful to people when they approached them and interacted with them. When staff approached people to support them with personal care, they greeted them and explained who they were and what they planned to do to support them.

People told us they were cared for by kind and helpful staff. One person told us "staff were kind, nothing is too much trouble, and they are supportive and friendly". Another person told us "staff are very helpful and friendly". People and their relatives told us they were happy with the care and had no concerns. One person told us that "staff are like family." Some staff also described people and colleagues as "like family."

We saw staff interacting warmly with people and staff demonstrated a person centred approach to relationship building. For example we saw a member of staff talking with a person in the communal living area. They were engaged in a conversation about a book the person was reading. This led onto the person talking about their past, their family and the weather. Throughout the conversation the staff member demonstrated listening skills, which included eye contact and a kind, open, friendly approach. They were interested in what the person was saying.

Staff responded to people in a timely and appropriate manner. For example staff got down to people's level when talking to them and responded quickly to people's questions and requests for help. Some people were able to engage in conversations with staff and we saw staff interacted with them and started conversations linked to people's different interests.

People had their privacy respected and their dignity maintained. One member of staff told us they were a "dignity champion." This meant they had received additional training and were able to train other staff in dignity in care. They described some of the exercises they used to make staff understand people's experiences. For example they put honey on staff hands and face and left them so that they could experience what is was like not to be supported with washing after meals. Staff told us they found this training helpful and influenced how they supported people to maintain their dignity.

Staff were polite and treated all people in a dignified manner. If people required support with personal care, they were supported discreetly back to their rooms to receive the necessary care in private. People told us they did not feel "hurried or rushed." During handover meetings staff spoke respectfully about people.

People and their families were supported to express their views and be actively involved in making decisions about their care. They were invited to a monthly review meeting. On the first day of our inspection there was a review meeting held. People and their families were involved in their care planning and decisions made about them.

Requires improvement

Is the service responsive?

Our findings

At our last inspection in February 2015 we had concerns about how the service ensured people received person centred care. Following the inspection the provider wrote to us and told us they would make improvements. During this inspection some improvements had been made. However further improvements were needed to ensure all care plans reflected people's likes, dislikes and preferences. There were inconsistencies for example, some people who had difficulties with communication did not have a detailed care plan and staff were not consistently aware of people's individual preferences and life story.

Some staff had worked in the service for a number of years and told us they knew people well and passed on this information to new staff. However when we asked staff about two people who were being cared for in bed, they were limited in how much they could tell us. For example they could tell us about the support the person needed with personal care but were unable to tell us about the person's background or interests and preferences. Staff were able to tell us when people were identified at risk, for example people at risk of choking or skin damage. This meant care and support for some people was not being provided to take into account their likes, dislikes and preferences. It also meant staff were not able to use the opportunity of talking with people during care and support about topics which the person may relate to or respond to. Some people's care plans were not sufficiently detailed to ensure that staff provided person centred care.

The registered manager told us improvements to care records was an on-going commitment. They had introduced a new system for reviewing people's care plans, which would ensure that people's preferences, likes and dislikes was included. There was a "resident of the day." This was a set day each month when there was a review of the care plan and all other aspects related to the home.

Further improvements to care records also included the introduction of new documentation planned for November 2015. The service had made improvements to person centred care plans however they had not completed a person centred care plan for all people in the home. Further improvements were needed to ensure consistency is achieved.

Some people were able to talk with staff about their preferences, likes and dislikes and were positive about staff. For example one person told us, "staff know me well; they know my likes, dislikes and preferences" and this was reflected in their care plan.

There was an activities co coordinator and activities were planned ahead for the month. People and relatives had asked if activities could be provided at weekends which was arranged. This demonstrated that people had some influence over the service provision. There was a wide range of activities, such as quizzes, reminiscing, singing, pampering sessions and craft. The co-coordinator told us when planning activities they aim to consider "mind, body, soul" and that each day they incorporate two of the categories. Group activities were held in the lounge and we saw several people participating during our inspection. For example during one activity there were 11 people. The activity timetable included external contributors for example, The Land Girls and a music entertainer. The activity co coordinator told us when planning the timetable they ask people what they would like to do and build it into the programme. For example one person told us they liked arts and craft.

There was one to one time allocated for people who either chose not to participate/unable to participate in group activities. For example the activity coordinator read to one person and some people had a hand massage. They also showed us photos of one to one sessions when they had arranged for a dog to visit, people were smiling and looked happy.

The service had different methods to listen and learn from peoples experiences. There was a monthly review meeting with people and their families. As well as this there was a quarterly "residents and family" meeting, a suggestion box, dedicated email address and a customer satisfaction questionnaire. There were examples of the service listening to people, such as the introduction of activities at weekends. There had been feedback that the garden was in need of tidying up. The service arranged a gardening weekend and some people and their families got involved.

There was a complaints procedure and how to make a complaint was on display. People told us they would talk with the manager if they had any concerns .One person told us they had raised a concern with the registered manager. They investigated the concern and it was dealt with informally and it did not escalate to a formal

Requires improvement

Is the service responsive?

complaint. The registered manager told us they encourage people to voice concerns and it is their role to investigate and seek resolution. There had not been any formal complaints.

Requires improvement

Is the service well-led?

Our findings

We found the provider had made improvements since our last inspection in February 2015. Our previous inspection found the service had not had a registered manager since 2011 and there were not effective quality monitoring systems. Following the inspection the provider wrote to us and told us they would make improvements. During this inspection we found some improvements had been made. However the quality monitoring systems were not sufficient to highlight when people did not have a personalised care plan.

The service was well led however further improvements were needed to quality monitoring systems. The registered manager was registered on 23 February 2015. They had made improvements and had an action plan detailing how further improvements were planned. However improvements were needed to quality checks of people's care plans. Each month the registered manager checked 10% of care plans and the regional manager also checked 10% care plans. However the checks did not highlight gaps in personalised care plans for some people. Some peoples care records were incomplete and did not have people's choices or interests completed. This meant that some people did not receive person centred care plan. Where checks had taken place, we saw actions were identified and issues resolved. For example one person did not have an oral assessment. Other checks included bed rails and hoists and home and environment, infection control and random MAR and medicine checks.

People, staff and health and social care professional had confidence in the registered manager to continue with on-going improvements. They were supported by a deputy manager and a clinical lead nurse. The regional manager attended the home twice a month. All staff we spoke with told us the registered manager was supportive and approachable. They told us that improvements had been made in the home and staff morale was "good." People told us they saw the registered manager regularly and would be happy to voice any concerns to them. One person said "I see [registered manager name], they come in my room and talk with me." Staff told us the registered manager had "a presence in the home."

Some people required an observation chart, these were a record of what checks people needed for example, which position the person was in or a record of the food and drink they had received. There were regular quality checks carried out twice a day on people's observation charts and we saw these had been signed by the registered nurse to say they had been done. This meant that if there were any gaps in the recording on the chart it was picked up the same shift and rectified. For example on one occasion a care worker did not sign that cream had been applied, the nurse identified this on the same shift and was able to remind the care worker to rectify it.

The registered manager kept track of actions from the checks and completed a home action plan which was sent to the regional manager on a weekly basis. As well as this there was a monthly clinical governance meeting. This meeting was to monitor quality through the checks and action plans as well as the learning from incidents and accidents.

Accidents and incidents were recorded on an electronic system. All events were investigated and signed off by the registered manager, who also monitored for any patterns or trends. The registered manager produced an action plan when needed which was fed back through to the regional manager and the clinical governance meeting. For example one person had unexpected weight loss, this was recorded on the electronic system and investigated by the registered manager. The action plan included, "for the chef to talk with the person about food preferences and prepare fortified food options."

The registered manager held meetings on a daily basis with heads of departments, which included the administrator, maintenance person and chef and nursing staff. This was a forum for discussing daily changes for example if someone was unwell or if there was any work being done in the home.

Staff told us they felt listened to and were able to contribute their ideas. For example the domestic staff was unhappy with some of the cleaning products and had raised this with management. It had been arranged for alternative products to be looked at. Staff understood their job roles and their responsibilities. Staff told us they were happy at work one care worker told us "I love working here."

The registered manager conducted daily" walk rounds" of the home which were recorded, any areas of concern were

Requires improvement

Is the service well-led?

resolved promptly for example, some boxes from a delivery needed moving and the registered manager addressed this. Nursing staff completed a 24 hour report which was sent to management on a daily basis.

The service operated an employee of the month award. Staff could nominate each other based on the values of the home. The successful member of staff received a gift voucher. Staff told us they like this award and it makes them feel "valued."