Willan House (Stainfield) Limited

Willan House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 22 June 2016 and was unannounced.

Willan House is registered to provide accommodation and personal care for up to 20 older people or people living with a dementia type illness. There were 16 people living at the service on the day of our inspection.

There was a registered manager in post at the time of our inspection. 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.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. The management and staff understood their responsibility and made appropriate referrals for assessment. Ten people at the time of our inspection had their freedom lawfully restricted.

People who lived in the service felt safe and staff knew what action to take and who to report to if they were concerned about the safety and welfare of the people in their care. People were kept safe because staff undertook appropriate risk assessments and care plans were developed to support people's needs. The registered manager ensured that there were sufficient numbers of staff to keep people safe and care for their needs.

People were cared for by staff who were supported to undertake training to improve their knowledge, understanding and skills to perform their roles and responsibilities.
People had their healthcare needs identified and were able to access healthcare professionals such as their GP or dentist. Staff knew how to access specialist professional help and emergency care when needed.

People were provided with nutritious home cooked meals that were made from fresh ingredients. There were plenty of hot and cold drinks available throughout the day.
People were supported to make decisions about their care and treatment and staff supported people with disabilities to maintain their independence. People were treated with dignity and respect by kind, caring and compassionate staff. People were treated as individuals and were enabled to follow their hobbies and pastimes. There were a wide range of activities provided.

There were systems in place to support people and their relatives to make comments about the service or raise concerns about the care they received. People and their relatives were encouraged to attend meetings and lunches with staff to discuss ways to improve the service. People told us that the registered manager and staff were approachable.

There were robust systems in place to monitor the quality of the service. Staff received feedback on the outcomes of audits, lessons were learnt and improvements to the service were made. The service had received national accreditation for end of life care.

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 enough staff on duty to meet people's needs.

Staff followed correct procedures when administering medicines.

Staff had access to safeguarding policies and procedures and knew how to keep people safe.

Is the service effective?

Good

The service was effective.

Staff had received appropriate training, and understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were cared for by staff who had the knowledge and skills to carry out their roles and responsibilities.

People were supported to have enough to eat and drink and have a nutritious and balanced diet.

People had their healthcare needs met by appropriate healthcare professionals.

Is the service caring?

Good

The service was caring.

Staff had a good relationship with people and treated them with kindness and compassion.

People were treated with dignity and staff members respected their choices, needs and preferences.

Is the service responsive?

Good

The service was responsive.

People's care was regularly assessed, planned and reviewed to

meet their individual care needs.

People were encouraged to maintain their hobbies and interests.

Is the service well-led?

Good

The service was well-led.

The provider had completed regular quality checks to help ensure that people received safe and appropriate care.

There was an open and positive culture which focused on people and staff.

People who lived in the service found the registered manager approachable.

Willan House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

The inspection took place on 22 June 2016 and was unannounced. We returned the following day to provide feedback on our inspection to the registered manager and the provider. The inspection team was made up of one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We used this information to help plan our inspection.

We also looked at information we held about the provider. This included notifications which are events which happened in the service that the registered provider is required to tell us about.

During our inspection we spoke with the registered manager, the provider, four members of care staff, the housekeeper, the activity coordinator and nine people who lived at the service. We also observed staff interacting with people in communal areas, providing care and support. Following our inspection we spoke with one relative by telephone.

We looked at a range of records related to the running of and the quality of the service. These included two staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the provider completed. We also looked at care plans for six people and medicine administration records for six people. In addition, we undertook a Short Observation Framework for Inspection (SOFI) at lunchtime. 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

People told us that they felt safe living in the service. We observed one person being assisted by a member of care staff to use the stair lift to come downstairs. The person said that the felt safe using the stair lift and that there was always a member of staff with them.

The provider had developed and trained their staff to understand and use policies and procedures to prevent people from avoidable harm, potential abuse and help keep them safe. Staff told us that they had received training on how to keep people safe, how to recognise signs of abuse and followed local safeguarding protocols. One staff member said, "You might see a change in them [people who lived at the service]. Different reaction, appear withdrawn, want to stay in their room." Another staff member said, "I would tell the senior carer or the manager. We can escalate to safeguarding, CQC. The numbers are in the office." There were systems in place to support staff when the registered manager was not on duty. For example, staff had access to guidance on how to keep people safe in event of a power failure. The service had a telephone that was not dependent on mains electricity that staff could use to contact the registered manager, the provider and essential services. In event of the building needing to be evacuated, people had a personal emergency evacuation plan and the local village hall would provide temporary accommodation.

People had their risk of harm assessed. We found that a range of risk assessments had been completed for each person for different aspects of their care such as the safe use of bed rails. Care plans were in place to enable staff to reduce the risk and maintain a person's safety.

We looked at two staff files and saw that there were robust recruitment processes in place that ensured all necessary safety checks were completed to ensure that a prospective staff member was suitable before they were appointed to post

The provider had a system for calculating the care dependency levels for the people who lived at the service. These dependency levels then informed the registered manager of how many staff with different skill levels were needed on each shift. An early evening shift had been introduced to support people with their evening meal and if they wished, to assist them to get ready for bed. We saw when a member of staff called in sick, that staff not on duty, could be called on to cover the shift. The service had not used agency staff this year.

We found that there were sufficient staff on duty to meet people's care and social needs, people had access to call bells and these were answered promptly. People told us that there were enough staff to look after their care needs.

People received their medicine from staff who had received training in medicines management and had been assessed as competent to administer them. People told us that they always received their medicine at the correct time and staff gave them pain relieving medicines if they were in pain. One person told us, "I have a pain in my hip but they've just rubbed some gel on it and I've had my tablets. It will soon clear." After lunchtime we observed medicines being administered to people and noted that appropriate safety checks were carried out and the administration records were completed. Staff were unable to take the medicine

trolley to people who remained in their bedroom on the first floor as there was only a stair lift. However, a senior member of care staff explained to us and we saw that a new administration system had been introduced and this helped to maintain the safe administration of medicine to people. All medicines in tablet form were stored in blister packs and staff took the MAR chart with the blister pack to the person rather than carry loose tablets in a medicine pot.

We looked at medicine administration records (MAR) for six people and found that medicines had been given consistently and there were no gaps in the MAR charts. Each MAR chart had a photograph of the person for identification purposes and any allergies and special instructions were recorded. Where a person did not receive their medicine a standard code was used to identify the reason, such as when a person declined to have their medicine.

All medicines were stored in accordance with legal requirements, such as locked cupboards and the medicines trolley. There were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner and out of date and unwanted medicines were returned promptly. Staff had access to guidance on the safe use of medicines and the medicines policy. We noted that when a medicine incident had occurred that the registered manager had taken appropriate steps to investigate the error and care staff received feedback and additional training.

Good

Is the service effective?

Our findings

People told us that staff had the knowledge and skills to carry out their roles and responsibilities. One person said, "They are good." A relative told us that staff knew what they were doing and said, "They are very good. They have really helped him. They know how to move him, to handle him, so gentle." Staff were provided with mandatory training such as health and safety and moving and handling and also, training specific to individual needs, such as supporting a person with a dementia type illness. The registered manager had recently provided staff with a training programme called "the virtual dementia experience". Staff told us that it was the closest thing to actually living with dementia and said that they now had a greater understanding of the difficulties people in their care experienced and how to better support them. One member of staff explained, "I experienced what it is like. How colour affects them. To speak clearly. It was emotionally draining and I was in a bad way afterwards. How do they feel?" In addition, staff had access to up to date national guidance on safe care practices, and the service had achieved "commended" status for the Gold Standards Framework (GSF). The GSF provides staff with the knowledge and resources to provide people with a high standard of care towards the end of their life and a dignified death.

In addition, staff were supported to work towards a nationally recognised qualification in health and social care and the registered manager had recently introduced the Care Certificate. This is a new training scheme supported by the government to give care staff the skills needed to care for people. New staff undertook a period of induction before they were assessed as competent to work on their own. Staff told us that their induction and mandatory training prepared them for their role. One recently appointed member of care staff said, "I've working my way through the Care Certificate. I have two modules left to do, first aid and resus [cardiac resuscitation]." Staff received regular supervision and appraisals and said that they were a positive experience and they welcomed feedback on their performance. The registered manager received peer support from an independent supervisor.

We observed that people's consent to care and treatment was sought by staff. For example, we saw that people had given their signed consent to have their photograph taken for identification purposes and to receive personal care. Where a person lacked capacity to give their consent staff followed the principles of the Mental Capacity Act 2005 (MCA).

The 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.

We saw where a person had lacked capacity to consent to their care that they had appointed a member of their family to act as their Lasting Power of Attorney (LPA). An LPA is someone registered with the Office of the Public Guardian to make decisions on behalf of a person who is unable to do so themselves. We spoke with a relative who was the representative for a person with a DoLS authorisation. They told us that they were aware of the DoLS and their responsibilities as the person's representative to act on their behalf.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirements in the DoLS and 10 applications had been submitted to the local authority and were approved. The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS.

People were provided with a well-balanced and nutritious diet. In addition, hot and cold drinks were provided throughout the day. People who lived at the service told us that there was always plenty to eat and drink and that the food was good. One person said, "The food is very good." Another person said, "It's tasty. It's lovely." Staff told us that they knew people's food likes and dislikes and one staff member said, "We know what they like. For example, [name of person] does not like sauce; cheese, sauce, parsley sauce, but will have gravy with everything."

The cook was not on duty during our inspection and the provider was preparing meals in their absence with the support of a kitchen assistant. The provider told us that they catered for people with special dietary needs and also fortified some dishes with dairy products to support people who may be at risk of weight loss. We noted that all dishes were homemade and made with fresh ingredients. Furthermore, people were provided with a portion size that they could manage. One person said, "If there is too much food on my plate can't eat it." A relative said that their loved one was well fed. They told us, "The food is good, he loves his food. It is pureed and his drinks are thickened. He eats when he is hungry and often at night they will make him anything he wants."

People were given a choice of where they took their meals, some choose the dining room and others preferred to take their meals in the lounge or their bedroom. People were supported to eat their meals without being disturbed. We observed staff assist a person who was registered partially sighted to eat their meal independently. A member of staff described to them what food they had and where it was placed on their plate.

We saw that a daily record was kept for the people who lived in the service of their food choice and food intake at each meal. The provider told us this helped identify when a person was off their food. We noted that one person had a history of toothache and complained that their mouth was sore. They were provided with a soft meal and an urgent appointment was made for them to visit their dentist.

The weather was warm and muggy on the day of our inspection. People were unable to access the garden as there were maintenance people cleaning the gutters and it was not safe for people to go outside. However, the provider offered people ice cream to help cool them down.

People were supported to maintain good health. We saw that people had access to healthcare services such as their GP, speech and language therapist, dietitian and dentist. If a person became unwell, staff had guidance in the form of a flow chart that supported them to make the correct decision to either contact a person's GP or call for emergency services.

We saw that people who lived in the service were supported to take regular physical exercise. For example, we observed 11 people with varying abilities take part in an armchair exercise class with an external coach. We saw that people were encouraged and praised for their efforts. The registered manager told us that the

incidence of falls had reduced since the exercise classes had been introduced and people had reported that they felt better for them and that their posture had improved.

Good

Is the service caring?

Our findings

People who lived at the service told us that they were looked after by kind, caring and compassionate staff. One person said, "I can't grumble. They [staff] are all nice people." A relative told us that staff were kind and caring and added, "Very pleased to find a home so caring and clean and they dress him so nice. The atmosphere is nice." We noted that care staff took time to sit and chat with people and listen to what they had to say. We observed staff interacting with people and saw that people and staff had a good relationship and there was lots of friendly banter. One member of staff said, "We get to know them individually. We sit and talk for a few minutes. Talk with them when giving them care. It's like a family." Another member of staff said, "We look after the person, not the disease. See the person and don't talk down to them."

We observed staff assist some people to walk to the dining room for their lunch. People were supported to walk at their own pace and staff chatted with them in a friendly manner. We saw that people sat in friendship groups to have their lunch and several were talking about the exercise class they had joined in that morning and how they would spend their time after lunch.

Three people were cared for in bed. We saw that care staff were attentive to their care needs and all were clean and comfortable. Measures were in place to reduce the risk of social isolation and loneliness with people who were cared for in their bedrooms. For example, one person had their bed situated in the middle of their bedroom, facing the window. They had bird feeders outside in the garden and family photographs on their window ledge. Staff also ensured that the person had their taste in music playing for them.

People had care plans tailored to meet their individual needs and they were encouraged to take part in reviews of their care plans. A member of care staff said, "It's all about choice. What do they want to eat, do they want to get dressed or have a bath." Another staff member said, "We ask them what they want to do. Do they want to watch TV or sit in the garden?"

There were measures in place to enable people to be familiar with their surroundings. For example, the signage for toilets and bathrooms was in both pictures and words. Some people had their name or a familiar photograph on their bedroom door so as they could identify it.

Some people had difficulty communicating their needs verbally or had hearing difficulties and we observed staff effectively support them to express their needs. We observed one person who was unable to talk use their eyes and facial expressions to inform staff of their needs. When we spoke with this person they blinked their eyes to let us know that they were happy and content with their care and looked at the registered manager for reassurance. Another person who was hard of hearing was shown a box of pain killing medicine to determine if he needed pain relief.

People were provided with information on how to access an advocate to support them through complex decision making. Advocacy services are independent of the service and local authority and can support people to make and communicate their wishes. We saw that one person had an advocate appointed to support them as they had no living family.

People were enabled to maintain contact with family and friends and people could receive visitors at any time. A relative told us that their loved one was always treated with dignity and said, "He is cared for in bed but they [care staff] always change him out of his pyjamas during the day and he wears a shirt. He always wore a collar and tie and it's nice that staff respect this."

We saw that people's right to their privacy and personal space was respected. For example, we noted that people had a sign on their bedroom door requesting that staff knock the door and wait for a reply before entering and we observed that staff respected this request. We saw that some people had the key to their bedroom door. This provided a sense of security and ensured that other people could not enter a person's bedroom without their permission.

We saw how small acts of kindness helped to maintain a person's dignity. For example, one person lost a button off their blouse and rather than risk other people seeing their underwear the provider gave them a small broach to wear on their blouse to maintain their dignity until their blouse could be mended.

The service had two double bedrooms. However, the register manager told us that these were rarely used and said, "We use them as single rooms to maintain dignity, privacy and choice. The last time a room was shared was four years ago for a married couple."

There was also a dignity tree where people who lived at the service, their relatives and staff could record how they expected to be treated by others to maintain their dignity.

Good

Is the service responsive?

Our findings

We found that people were encouraged to spend their time how and where they wished. We saw that some people chose to sit in the lounge or conservatory whereas others preferred to return to their bedroom between meals.

People had their care needs assessed and personalised care plans were introduced to outline the care they received. Care was person centred and people and their relatives were involved in planning their care. A relative told us, "We are always kept informed. He has a lovely key worker we can talk with any time." The care plans were written to a high standard and easy to read and access information. We saw that individual care plans focused on supporting a person to live well with their health problems and maintain their independence. For example, one person found getting dressed painful. Their clothes had been adapted to making dressing pain free. Another person who was partially sighted had a care plan that recorded not to make assumptions about their ability and to provide them with a well-lit environment.

Some people invited us to look at their bedroom. We found that they were supported to personalise their bedroom with items from home such as pieces of furniture, family photographs and keepsakes. We saw that most people living with dementia had items that reflected a time in their life that was important to them. For example, one person had been a dog breeder and they had photographs on display of their dogs.

The shared areas of the service, such as the lounge and dining room had furniture representative of the 1950s and 60s. There was also a cabinet with lots of memorabilia from that era and scrap books. We were told that people like to use these objects to reminisce about their younger lives and could share their personal experience with each other.

People were supported to follow their own spiritual or religious beliefs and visits were made by representatives from different religious persuasions. Furthermore, we saw that some people had personal items in their bedroom reflecting their beliefs. People were also given the opportunity to use their vote in a recent national referendum and had been supported to complete a postal vote.

Staff helped people to celebrate special occasions and meaningful events. For example, we saw that there was bunting hanging in the conservatory and dining room for the Queen's 90th birthday celebrations. We also saw that one person had celebrated a special birthday the previous week. This person was cared for in bed and they had a birthday balloon tied to their bed rail. Furthermore, we saw photographs of their birthday cake. It was made with chocolate mousse and raspberries as they had swallowing difficulties and were unable to swallow sponge cake. Their relative told us that the registered manager had put on "spread" for his relatives to celebrate.

People who lived in the service were supported by an activity coordinator to follow their interests and hobbies and enabled to interact socially with each other. One person told us, "We do lots to keep busy." After lunch we observed that some people were reading the daily newspaper, chatting with their friends about magazine articles or knitting. The activity coordinator asked people what they would like to do and

we watched 13 people of varying physical and sensory difficulties enjoyed a game of skittles. There was a lot of cheering, laughter and applause and when people took their turn they made comments such as, "I'll show you how it's done."

People who lived in the service were asked for their feedback on the service at their monthly care plan reviews and through a quality assurance questionnaire. We saw that their feedback was positive and comments recorded such as, "Very good food and enjoyable" and "staff are wonderful."

There was a suggestion box at the front door for people and their relatives to give their thoughts on the service. However, the registered manager told us that it had been sometime since they had received any. However, the registered manager did share with us compliments that had been received about the care people had received. We saw a letter from one person's relatives following their death that read, "Highest possible standard, all standards excelled. Thank you for the photograph album with lots of memories. A lovely touch."

People had access to information on how to make a complaint, and told us that they had no reason to complain and could talk with staff at any time. Staff told us that if a person complained to them they would escalate the concern to the register manager or the deputy manager. The registered manager had not received any formal complaints in the last 12 months.

Good

Is the service well-led?

Our findings

People who lived at the service were invited to regular meetings led by the activity coordinator and could input to the agenda. The registered manager did not hold formal meetings with relatives. Instead they had "relatives" lunches where people and their relatives could come together in an informal setting and share their ideas about the service.

Staff told us that they found the registered manager approachable and supportive. One staff member said, "They are good bosses. You can go to them at any time, with any problem." All staff attended regular team meetings with the registered manager. We read the minutes from the meetings held in March and June 2016. Staff discussed topics pertinent to their roles such as, medicines, infection control and future training opportunities.

We found that the registered manager and provider were visible leaders and knew their staff and the people in their care. The people who lived in the service told us that they knew who the registered manager was and knew them by name. A relative told us that the registered manager was very approachable and said, "They always pop their head round the door and ask if everything is ok. We feel welcome."

Staff told us that they were a good team and that they were proud to work in the service. One staff member said, "We have a good team and we all work well together." Another member of staff said, "I really enjoy it. They [people who lived at the service] give a lot back. You get a thank you and it means everything."

Staff had access to policies and procedures on a range of topics relevant to their roles. For example, we saw policies on safeguarding and infection control and guidance on skin care. Staff were aware of the whistle blowing policy, knew where to find it and knew how to raise concerns about the care people received with the registered manager. The registered manager had a rolling programme to review policies and ensure that they were up to date with current best practice guidelines. The continence policy was under review at the time of our inspection.

We found that recent whistle blowing concerns had been investigated by the registered manager and appropriate actions had been taken. The registered manager had a system where accidents and incidents were investigated, outcomes were shared with staff, additional training and assessment were provided when needed and lessons were learnt to help prevent a reoccurrence.

A rolling programme of regular audit was in place that covered key areas such as continence and medicines. Action plans with realistic time scales were produced to address any areas in need of improvement. The audit outcomes and required actions were shared with staff. In addition, the registered manager undertook an annual improvement audit that covered all areas of service. For example, it was identified that signs should be laminated and some areas required new floor covering.