Tamaris (South East) Limited

Ross Wyld Care Home

Inspection report

458 Forest Road
Walthamstow
London
E17 4PZ

Tel: 02085218773
Website: www.fshc.co.uk

Date of inspection visit:
16 December 2015
18 December 2015

Date of publication:
10 February 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Ross Wyld Care Home is a purpose built care home providing residential and nursing care to up to 50 people. There is 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.

The home was last inspected in May 2014 when it was found to be compliant with all the standards inspected.

People were kept safe from avoidable harm and abuse and were supported by staff that had been recruited safely. There were support and risk management plans in place and where risks had been identified there were plans in place to minimise them. Plans were reviewed and updated regularly and were personalised to individual needs. There were robust systems in place to ensure that the building was safe for people, and checks were performed regularly to ensure it remained so.

There were enough staff to support people. People were supported to take their medicines as prescribed and there were robust systems in place to ensure this was done safely.

People were supported by staff who had the knowledge and skills required to carry out their roles, including professionals registrations where required. Staff received regular training. Staff supervision was not clearly documented. We have made a recommendation about staff supervision.

Peoples consent to their care was sought in line with legal requirements and the service was following the Mental Capacity Act 2005 and associated guidance including regarding Deprivation of Liberty Safeguards.

People told us they liked the food and their nutrition and hydration needs were met, including where they followed special medical or religious diets. People were supported to maintain their health and the service had good links with relevant health professionals.

Positive relationships had been developed between people, their relatives and staff. People were offered choice and their privacy and dignity was respected. People were supported to have their cultural needs met.

The service sought and responded to feedback from people, relatives and professionals. There was a clear complaints policy in place which the provider followed when complaints were made.

There was a positive, open, person centred culture at the service which was led by the registered manager.

There were robust quality assurance systems in place to obtain feedback and monitor performance.

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.

People felt safe and there were robust systems in place to prevent harm.

There were enough staff who were suitable to work in the home.

People were supported safely, in a kind and patient way, to take their medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training, but supervision was not always effective.

People consented to their care in line with legislation and guidance.

People were supported to eat and drink enough to maintain a healthy, balanced diet.

The service supported people to maintain their health and access healthcare services as needed.

Is the service caring?

Good

The service was caring.

Positive relationships between staff and people were developed through time and good documentation.

People were involved in making decisions about their care and this was clearly recorded.

People's privacy and dignity was maintained at all times.

People's cultural and religious backgrounds were respected and supported.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was quickly adjusted if their needs changed.

A wide range of activities were offered and people told us they enjoyed them.

The service had a robust complaints policy and complaints were responded to appropriately. People were listened to and the service made changes as a result of feedback.

Is the service well-led?

Good

The service was well led.

The registered manager was highly visible and promoted a person centred, inclusive culture.

There were effective quality assurance and management systems in place.

The systems in place ensured the service was delivering high quality care.

Ross Wyld 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 16 and 18 December and was unannounced.

The inspection team consisted of three inspectors, an inspection assistant and a specialist advisor with expertise in nursing care for the elderly.

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 improvements they plan to make. We sought feedback from the local authority commissioning and safeguarding teams, the ambulance service, the local healthwatch and advocacy groups.

During the inspection we spoke with twelve people who used the service, four relatives of people who lived in the home, five care assistants, two nurses, the chef, the maintenance person, the deputy manager and the registered manager. We looked at eight people's care files, eight staff files, staff duty rotas, a range of audits and feedback, various meeting minutes, maintenance logs, incident and accident log, safeguarding records, activities timetable, food menus and policies and procedures for the home and other documents relevant to the management of the service. We observed care and support in communal areas and also looked at some people's bedrooms and bathrooms, with their permission. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific 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 they felt safe at the home. One person said, "It is safe here…I don't worry about my possessions." A relative told us, "[my relative] feels safe here. This brings me peace of mind." The home had a robust safeguarding policy which included details of types of abuse and who and how to report concerns. Staff told us they would report any concerns they had to a senior member of staff or to the manager who would take action. One staff member said, "Safeguarding is important to us here. We need to ensure that residents are safe." Records confirmed that the service took action where they were concerned that people may have been abused. The home notified both the local authority and CQC of any safeguarding allegations. Records showed that staff received training on safeguarding and whistleblowing.

Care files contained risk assessments that addressed risks identified in the individual needs assessments. Where appropriate people had risk assessments addressing moving and handling, use of mobility aids, falls prevention, nutrition, swallowing, skin integrity, psychological wellbeing and behaviour that may challenge services. The files showed that risk assessments were reviewed every four to six weeks and updated in response to changing needs. For example, one person's mobility risk assessment had been updated following a fall. Senior carers and nurses were responsible for writing and updating risk assessments and staff told us they would alert the staff responsible if they identified a risk that had not been addressed. Staff told us, and records confirmed, that updates to risk assessments were communicated through daily handovers.

The home had appropriate building and fire risk assessments and a system of maintenance checks to ensure the building was safe for people. Records showed that regular checks were completed on water temperatures, flushing of unused taps, hot surfaces, alarm call system, wheelchairs, extractor fans, gas and electrical safety, tall furniture, fire safety equipment and alarms, emergency lighting and doors. In addition regular fire evacuation practices were held which recorded whether staff responded appropriately and identified training needs. Records showed that all these checks were completed by a dedicated member of staff, however, when this person was on leave the checks did not take place. This was brought to the attention of the registered manager as a potential risk. Since our visit the registered manager has named an additional person as cover for this member of staff and they have been scheduled to attend training to ensure they can fulfil this role. The home ensured that external health and safety checks were completed as required.

People and their relatives told us they thought there were enough staff on duty to meet their needs. One person said, "There are enough staff here, and I had a buzzer to call them when I was in my room." We saw that there were enough staff to meet people's needs and people did not have to wait to be supported. The service used a dependency tool to calculate minimum staffing levels, and the registered manager informed us that they used additional hours to facilitate staff support out of the home for hospital appointments and activities. Staff told us that unexpected absences were covered from within the staff team and this usually worked. One member of staff told us this system worked "70% of the time, sometimes it doesn't and we are short. This means we are busy, but it is not unsafe. We work as a team." The home did not use agency staff to cover absences.

The registered manager told us they ran a rolling programme of recruitment to ensure that the service has enough staff. In addition, they recruited trained nurses who were awaiting their accreditation from the Nursing and Midwifery Council as senior care assistants. This meant that as soon as their registration had been confirmed they were able to start working as nurses. These staff were already familiar with the service and the needs of the people as they had received their induction.

The service had a robust recruitment policy which detailed the processes that should be followed to ensure suitable staff were recruited to work in the home. Records showed that the service checked people's identities, and performed disclosure and barring service checks to ensure that people did not have criminal convictions that would make them unsuitable to work in a care environment. Where appropriate, professional registration documentation was provided. Records of the recruitment process were not always clear, for example, if references were provided over the telephone rather than in writing it was not clear how this had been verified. As a result of our feedback the registered manager audited the files and ensured that information was clarified.

People who lived at the home were supported by staff to take their medicines. One person told us about the medicines they received and it was clearly documented that though this person was capable of self-administering they chose for staff to do this. Medicines were administered by trained staff. Training was completed annually and competencies were assessed by qualified staff. Information on medicines and their side effects was available to staff, as was the home's medicines policy. Where non-nursing staff administered medicines they wore a tabard indicating that they should not be disturbed, nurses administering medicines did not wear a tabard. One nurse told us they are occasionally interrupted while administering medicines but this was rare.

We observed medicines administration during our inspection and saw that the processes followed were in line with the policy and procedure. This ensured that people received their medicines as prescribed. Staff took their time to explain to each person what their medicines were and checked whether or not they required medicines, such as pain relief, that were prescribed on an "as needed" (PRN) basis. There were clear guidelines in people's files to describe when PRN medicine may be required. Staff obtained consent from each person before administering their medicines. Refusals were clearly documented, and where appropriately assessed and documented covert administration was completed. This means that the person had their medicines hidden or disguised in food.

The home administered Controlled Drugs. These are medicines where there are additional regulations around storage, administration and destruction due to their nature. The home had appropriate storage facilities and administration was completed in a safe and compliant manner. The deputy manager, a registered nurse, clearly explained the disposal process. Records viewed confirmed that staff were following the correct procedures for the administration and counting of controlled drugs.

The home used a monitored dosage system, where medicines were stored in blister packs, and used printed medicines administration records to record that medicines had been given to people. These were checked for errors daily. We found one unexplained missing signature during our inspection. The registered manager showed us that the documentation regarding this had been completed in the handover record. The home conducted medicines audits, where they counted medicines supplies and ensured they matched the records, every week. Records confirmed these took place. Medicines were administered safely.

Medicines were stored securely in a dedicated locked room. Records showed the temperature of this room was kept at a suitable level for the storage of medicines. The room was crowded as it was also used to store archive medicines administration records. The registered manager told us she was in the process of having a

room converted into additional storage for archive material which will make the room less crowded. We also observed that the fridge used to store medicines which required refrigeration was over-full. The registered manager took immediate action and ordered an additional medicines fridge that day. The fridge was locked and the temperature was checked and recorded daily. Medicines were being stored at a safe temperature.

Requires Improvement

Is the service effective?

Our findings

One person told us, "They [the staff] do a good job." Staff told us, and records confirmed, they completed training in key areas. Training records showed staff received training in moving and handling, person centred care, nutrition and risk of malnutrition, medicines, infection control, fire safety, settle in (this related to when new residents moved in), dementia, pressure wound prevention and care, distress reaction training (this related to people who exhibited behaviours which may challenge services). In addition, staff had received specific training in some medical equipment as well as vocational health and social care qualifications at levels 2, 3 and 5. On the day of our inspection, nursing staff were receiving training from the community matron on "The unwell resident."

One of the floors in the home was a dementia specialist unit. Staff told us they were not able to work on that floor until they had completed their dementia training. Staff also told us they found the training they had completed useful, particularly the moving and handling training. One member of staff said, "It's not so easy, but it's good. It keeps us and the residents safe." Most training provided was e-learning which staff were asked to complete at home. However, if staff were having difficulty doing this the registered manager made arrangements for them to complete the training at the home. In addition, where staff found completing the training more challenging the registered manager allocated them a mentor to support them to complete their training. This meant staff were supported to develop their skills to provide good care to people living in the home.

Staff told us that they received a three day induction to the service. During these days they shadowed a senior colleague, read people's care plans and built up their relationships with people. They then worked with colleagues, who shadowed them before working independently. Staff files contained an induction checklist which confirmed staff had received the relevant policies, training and support with their new role.

The home had a supervision policy which stated staff should receive a minimum of six supervisions per year. Staff told us they received supervision regularly and found this helpful as it addressed performance issues. They told us, and records confirmed supervisions were conducted by the senior on duty that day. Staff did not have a named, regular supervisor. This means there was no consistency for staff. The registered manager provided us with a supervision matrix which had 70 staff named on it. The matrix did not differentiate between group and individual supervision sessions, and records indicated that some of these supervisions were brief information sharing sessions rather than discussions of individual work performance. Records did not detail the content of discussions, rather just the topics that were covered. Clinical supervisions were provided for nurses and were led by the deputy manager who was a registered nurse. However, the records of these were also brief and did not include the content of discussions. The registered manager told us that clinical supervisions were used to address issues on the floor, as well as specific clinical issues. The registered manager told us they would ensure recording of supervisions was more detailed and that the provider was going to introduce new supervision templates in early 2016.

We recommend the service seeks and follows best practice guidance on providing effective supervision to clinical and non-clinical staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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 service was appropriately applying for and executing the conditions of DoLS authorisations in place. They were notifying CQC in line with their statutory obligations.

Staff told us that they sought consent from people for daily care tasks and people confirmed this. One person said, "Staff always ask permission before they support me." Each care file contained a section called, "Rights, consent and capacity needs, including legal status." This section documented people's consent to their care and treatment, including whether or not they had a legally appointed representative to do this on their behalf. It also detailed the person's capacity to make decisions, both complex and straightforward and provided information on DoLS for the individual. Records showed there were some situations where decisions had not been made on behalf of people who lacked capacity as relatives could not be contacted. For example, one person had not received a flu jab because their family could not be contacted to be involved. This was discussed with the registered manager, and the impact of not being able to involve the family in this decision had been weighed against the impact of the person not having their vaccine. This means that consent was sought in like with legislation and guidance.

People spoke positively about the food and told us they liked the menus. One person said, "I like the food here." Another person said, "The menus have improved, I now eat my veg." A third person told us, "The food's very tasty." We spoke with the chef who knew people's dietary needs and the importance of supporting healthy eating. People had nutrition profiles which stated any allergies or intolerances to food as well as preferences, for example, "No Pork" and how food should be prepared. In order to meet the dietary needs of people from different cultures and faiths, the chef and registered manager were working with external catering services to ensure that people who wanted a diet that was consistent with their religious beliefs received this.

The home had made a number of changes to their menus in response to feedback given. People were offered fruit smoothies and we observed fresh fruit being offered at snack times which people enjoyed. If people did not like what was on the menu, they were offered an alternative which was prepared for them. One person told us, "If you don't fancy what's on the menu they will do you something else." We observed both breakfast and lunch in different parts of the home and saw that people were offered choices of both food and drinks. Mealtimes were calm and people were provided with the support they needed to eat in a sensitive and appropriate manner; they were not rushed. We saw that people were offered drinks throughout the day, not just as set times. People who stayed in their rooms showed us they had sufficient amounts to drink as jugs of water or other cold drinks were available to them.

The service worked with health professionals to ensure that people were receiving a healthy, nutritious diet. People at risk of malnutrition were monitored closely and where appropriate given food supplements and fortified drinks. People who had diabetes had their sugar levels monitored by nursing staff and were offered sugar free food choices. The chef told us, "We use sweetener if they want a bit of sweetness." Any specific support need, such as risk of malnutrition or choking, was clearly recorded in people's support plans.

Care files showed that people's health care needs were clearly documented. The home had good links with community health professionals. The community matron visited regularly and the GP visited once a week. Records showed appropriate referrals were made to health professionals, such as physiotherapists and tissue viability nurses when required. People told us the staff were supportive of their health needs, and we observed people being appropriately prompted to follow medical advice. Staff supported people to access health appointments, one person confirmed to us, "I love it when a carer accompanies me to hospital." Staff told us, and records confirmed, that concerns about, or changes in people's health needs were recorded in people's care plans and communicated through handovers. This means that people were supported to maintain good health through ongoing access to healthcare services.

Good

Is the service caring?

Our findings

People and their relatives told us the staff were caring. One person said, "They really look after you here, I really enjoy it." Another person told us, "The staff really do care." We observed staff supporting people in a caring and sensitive manner, talking with people about their lives before they lived in the home and sharing stories. Staff told us they had time to build up relationships with the people they supported. Where possible, people and their families helped complete care plans so they contained details of people's pasts as well as preferences and dislikes. Records were personalised and contained the information needed to get to know someone.

Care files clearly documented where people had expressed preferences in terms of how they liked their care to be delivered. People's preferences in terms of the gender of their carer and the timing of their support were clearly recorded. In addition, some people had chosen to complete a "My Choices" document which recorded details of their life history, important relationships and happiest memories. The document also described what good and bad days looked like. We saw for one person their preference for culturally specific music was being respected as this was playing in the room. Staff recognised that when supporting people with dementia they needed to be patient and recognised that preferences can change. Staff told us, and people confirmed, that choices around care were offered each time support was provided. We observed people being offered choices around their care during the course of our inspection.

A relative told us, "I feel like my [relative] is always treated with dignity and respect." Staff described how they maintained people's dignity during care by knocking on their doors, keeping doors shut during care and keeping people covered. One member of staff said, "I think as if I am in their place, I wouldn't want people to see." Staff told us how they talk people through their support, and we observed this to be the case. For example, people were offered the choice to wipe their hands before a snack and one person required support to do this, the staff explained what they were doing as they supported them.

People's cultural needs were met by the service. Representatives of various faiths visited the home regularly and where religious belief had an impact on the type or style of care received this was respected. A number of people who did not speak English as a first language lived in the home, and staff who spoke their mother tongue spend time with them to help all staff understand their background and history. For example, a member of staff who was not in a caring role spoke the same language as a person who was bedbound. We saw that staff member made time to go and talk to the person in their mother tongue and explain to other staff what they were saying. Another member of staff explained how they had discovered the previous work history of one person because they had been able to speak to them in their native language. The home had culturally themed days where people would experience the food and music of a specific culture.

Good

Is the service responsive?

Our findings

Care plans were detailed and personalised and people told us they received care in a personalised way. One person told us, "I'm given a choice." New people moving to the home received a needs assessment conducted by the deputy manager. People and their relatives were encouraged to visit the home before making a decision. During our inspection we spoke with some people who were considering if the home was suitable for their relative. They told us that the home had been, "Open and honest. I am satisfied and happy for my relative to come here." Their relative moved in later that day.

Care plans were reviewed every four to six weeks and more frequently if people's needs had changed. It was clearly documented when people's needs had changed and what the current support looked like. For example, it was clear that one person had had a significant change of needs since they moved in as their health condition had deteriorated. It was clearly recorded what actions the home had taken and where they had sought additional support from external professionals including doctors and social workers. Staff told us they would report any concerns about changing needs to a senior member of staff who would take action. This was confirmed by records viewed. Records showed that people were involved in reviewing and updating their care plans. This was shown by reference to their opinions in the plans, which were person centred. Three relatives told us they had been involved in reviewing their relative's care through attending the review meetings.

People we spoke with told us they had not had any complaints, but that they would approach the registered manager if they had an issue. The complaints procedure was clearly displayed in the service. One person said, "I would go to [registered manager] if I had a complaint, I have never had to make a complaint."

The registered manager told us they had an open door policy where staff and people could raise complaints. Staff and people confirmed that the registered manager was easy to approach to raise issues with. Three formal complaints had been made in the last year. We reviewed these and saw they had been logged and responded to in accordance with the provider's policy. The matters were closed and the complainants received a detailed response. The registered manager worked closely with people and their relatives to resolve their complaints. The service collected feedback from relatives and professionals using tablet computers. This showed that people were happy with the care provided at the home.

A relative told us, "I feel like I can always make comments and raise issues at the staff office, and there are plenty of people to talk to on the floor up here." There were regular meetings for relatives where they could raise any issues or concerns. The registered manager had appointed a residents representative who also attended these meetings. Feedback had been received regarding meal choices, and the menus had been updated in response. People who lived in the home told us they would tell any staff, or the registered manager if they had any feedback. They were confident things would change as a result.

The home employed an activities coordinator who was supported by volunteers to provide a range of activities both inside and outside of the home. The home was decorated with home-made Christmas decorations which people confirmed they had been involved in making. People talked very positively about

the activities on offer and we saw people being encouraged and supported to participate in activities on offer. A relative told us, "There's always lots going on here." This was confirmed by the people we spoke with who described trips out to see the Christmas lights, visiting carol singers, regular film screenings, going to the local pub and to the theatre. One person confirmed, "They [activities] don't ever get cancelled." The home had built up links with local community groups and accessed local activities put on by a gallery.

The registered manager encouraged all people living in the home to leave their bedrooms and be involved in some kind of activity. Where people were unable to leave their rooms, staff supported them in their rooms to engage in different activities. Staff had hand-made "tweedlemoths" (soft fabric items) that were given to people to hold and play with. This is recognised as being particularly beneficial for people with dementia who struggle to maintain an activity for a long time but want to be occupied.

Good

Is the service well-led?

Our findings

People, their relatives and staff all spoke highly of the registered manager and their leadership. A relative said, "I really admire her and she is very good at what she does." A person told us, "She is very visible and listens to us when we have something to say." And a member of staff said,"[The registered manager] is very proactive, she's very involved with the residents, very positive, she speaks with us [staff] and tells us what is happening."

The registered manager described her approach as "Person and staff centred" and this was confirmed by staff who described her commitment to the people using the service, and to supporting them. For example, the registered manager provided mentoring for staff who needed more support and arranged for staff to work flexible shifts if they had commitments, such as childcare, outside of work. Staff told us they felt they could approach the manager with any concerns or issues.

The service held regular staff meetings, and staff received annual appraisals from the registered manager. The registered manager told us, and staff confirmed, that appraisals were used to identify where staff had the potential to develop into more senior roles and to suggest training that will support them with this. Staff told us they found staff meetings helpful. One staff member said, "At staff meetings I feel well listened to, and am able to bring problems to the table." On the second day of our inspection the service was having a party where long service of staff was recognised with awards.

The service had formal mechanisms for people, staff and relatives to provide feedback that complimented the registered manager's open door policy. There were tablet computers available that people could use to provide feedback. Records showed that these were well used and most people were happy with the service the home was providing. The manager followed up where people were not happy. For example, the menus had been changed as a result of feedback received.

The service had a robust system of audit and quality assurance mechanisms that ensured the home was delivering a high quality service. The records showed that the registered manager checked the experience of people living in the home and the standard of paperwork on a daily basis. In addition, checks were made of staff records and training, maintenance, medicines, and health and safety issues. Feedback was collected from relatives and professionals and this was used to improve service. Staff working in the home, including the registered manager had made the "Quality Care Commitment." This is a commitment made by people working in adult social care to improve the quality of services. The service had a dementia champion whose role included promoting understanding of dementia among staff. There was a best practice folder available to staff which included examples of best practice support for them to adopt.

The registered manager told us of their plans to improve the service. These included making changes to the building to increase the storage space and building on links with local community groups to increase activities. The plans included to develop a sensory garden with raised beds, this builds on the work already completed by a volunteer who does gardening with people.