Wendleberrie Care Ltd

Wendleberrie House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 26 February 2018 and was unannounced.

Wendleberrie House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Wendleberrie House provides accommodation and personal care. The location is registered to provide care for up to 15 people including older people and people living with dementia. At the time of our inspection, 14 people were in residence at the home.

At our last inspection in March 2016, the service was rated overall as good. At this inspection, we found that improvements were required and the service was overall rated as requires improvement.

There was a registered manager in post who was also the registered provider. 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.

Staff training and the induction process for new staff required strengthening to ensure that staff had the required skills to fulfil their role effectively. Recruitment practices required improving to ensure that thorough safe procedures were followed when recruiting new staff.

We made a recommendation about induction training for staff.

The processes in place for people to choose meals, drinks and snacks required enhancing to ensure that people were able to have choices and maintain their independence.

The systems and processes in place to assess, monitor and manage the risks relating to the health, safety and welfare of people using the service required strengthening. The audits in place required more detail to ensure they were effective.

People were safeguarded from harm as the provider had effective systems in place to prevent, recognise and report concerns to the relevant authorities. Staff knew how to recognise harm and were knowledgeable about the steps they should take if they were concerned that someone may be at risk.

Staff knew their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005) and Deprivation of Liberty Safeguards (DoLS) and had applied that knowledge appropriately. Staff understood the importance of obtaining people's consent when supporting them with their daily living needs.

People experienced caring relationships with staff and good interaction was evident, as staff took time to listen and understand what people needed.

There were sufficient numbers of experienced staff that were supported to carry out their roles to meet the assessed needs of people living at the home. People's care and support needs were monitored and reviewed to ensure that care was provided in the way they needed. People or their representative had been involved in planning and reviewing their care and plans of care were in place to guide staff in delivering their care and support.

People's health and well-being was monitored by staff and they were supported to access health professionals in a timely manner when they needed to. People were supported to have sufficient amounts to eat and drink to maintain a balanced diet.

People were supported to take their medicines as prescribed and maintain good health and had access to healthcare services when needed.

People's needs were met in line with their individual care plans and assessed needs. Staff took time to get to know people and ensured that people's care was tailored to their individual needs.

People and their relatives were confident that if they had any complaints they would be addressed and that any concerns they had would be listened to and acted upon.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Recruitment procedures required strengthening and infection control audits were not in place.

Staff had received training in safeguarding and knew how to report any concerns they may have.

People were supported to take their medication as prescribed.

Lessons were learnt after accidents, incidents or investigations.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The induction, supervision and training processes for staff required improving.

People had access to healthcare services and received on-going healthcare support.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA).

People's needs were met by the design and adaptation of the building.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always maintained and respected.

Positive relationships had developed between people and staff. People were treated with kindness and respect.

People and where appropriate their families were involved in making decisions about their care and support.

There were measures in place to ensure that people's confidentiality was protected.

Is the service responsive?

Good

The service was responsive.

People's care records were personalised and outlined how they wanted staff to support them.

People were actively engaged in a range of activities.

People and their relatives told us they knew how to make a complaint.

People were involved in discussions about end of life care.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems in place to monitor the safety and effectiveness of the service required strengthening.

Audits were not detailed enough and in some cases not in place to ensure that the quality of the service was maintained.

Opportunities for people, their relatives and health professionals to provide feedback about the quality of the service required improving.

Wendleberrie 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.

This was a comprehensive inspection. The inspection was unannounced and took place on 26 February 2018. The inspection was undertaken by an inspector and an inspection manager.

As part of this inspection, we spent time with people who used the service talking with them and observing support; this helped us understand their experience of using the service. We observed how staff interacted and engaged with people who used the service during individual tasks and activities.

Before our inspection, we reviewed the information we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events, which the service is required to send to us by law.

Due to technical problems, the Care Quality Commission did not receive a Provider Information Return; however we able to view the completed version on the day of the inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During our inspection, we spoke with five people using the service and three relatives and/or friends. We spoke with three care staff and the registered manager. We contacted health and social care professionals to gain their views of the service.

We also spent time looking at records, including four care records, four staff files, medication administration record (MAR) sheets, staff training plans, complaints and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Safe recruitment practices were not always followed. Records demonstrated that checks completed included two reference checks, criminal records checks, visa checks and a full employment history review. However, the registered manager had not risk assessed a new member of staff who was working in the home prior to a full disclosure and barring check being completed. The registered manager had verbally told the staff team that the new member of staff was only shadowing other staff and must not work alone; but there was no risk assessments in place to evidence this. We discussed our concerns with the registered manager who informed us they would complete a risk assessment.

The prevention and control of infection practices required strengthening. At the appropriate times, staff were using personal protective equipment (PPE) such as gloves, hand gel and aprons. One person told us. "It is always clean here; they [staff] do a great job." However, there were cotton hand towels used in the downstairs bathroom, which is not best practice for infection control, and there were no infection control auditing processes in place for the registered manager to have the oversight of infection control in the home.

People's medicines were mostly managed safely and administered by staff at the prescribed times. However, staff who administered medicines did not receive competency checks throughout the year to ensure that they were still competent and following best practice guidelines. One person told us, "I take quite a few tablets and I always get them when I should." A relative told us, "I am often here when [person] has their tablets; it can be difficult to get [person] to take them but the staff do a good job of encouraging them." We reviewed the medicine procedures and found that people were given their medicines in a way that met their individual needs. Medicines were stored securely and Medication Administration Records (MAR) were mostly completed accurately after each person had received their medication. We gave feedback to the registered manager about some medicines that were required to be returned to the pharmacy and ensuring that the appropriate codes were used on the medication administration records.

People told us they felt safe living at the service. One person told us, "There is always staff around and they lock the door, which makes me feel safe." A person's friend told us, "I have no concerns at all about the safety of [person]."

Safeguarding policies and procedures were in place and were accessible to staff; staff had been provided with safeguarding training. One staff member said, "We get regular training about safeguarding and I know how and who to report any concerns to." Procedures to follow for reporting safeguarding alerts to the local authority were displayed in the home.

People's needs were regularly reviewed. Risks to people were identified and steps taken to mitigate these risks whilst supporting people's independence. One staff member told us, "We have lots of risk assessments, for example risk assessments on using the hoist." Staff told us how risks to people were assessed to promote their safety and to protect them from harm. They described the processes used to manage identifiable risks to individuals such as, malnutrition, moving and handling, behaviour that may challenge and falls. One staff

member told us, "We risk assess the mobility of [person] every day and depending on how they are we will use a stand aid [moving and handling equipment] or a hoist." Staff told us that risk assessments were reflective of people's current needs and guided them as to the care people needed to keep them safe.

People were supported by sufficient numbers of staff to keep them safe and to meet their care and support needs in a timely manner. There was a skill mix of staff, which meant peoples diverse needs were met by a staff team who were knowledgeable and able to deliver care safely. People, relatives and staff told us they thought there was enough staff deployed to meet people's needs in a timely manner. One person said, "I only have to press my buzzer and the staff will come, they are always there within a couple of minutes." One relative said "Fantastic staff, always ready to help; they can't do enough for [person]." Care staff told us that they thought there was enough staff to meet people's needs.

There were systems in place for staff to report incidents and accidents and we saw these had been recorded and reported accurately. The staff we spoke with felt that any learning that came from incidents, accidents or errors was communicated well to the staff team through team meetings and handovers if required.

Requires Improvement

Is the service effective?

Our findings

Newly employed staff were required to complete an induction before starting work. However, the induction process did not contain sufficient information, knowledge and training for staff for them to undertake their role effectively. The induction processes consisted of reading policies and procedures and familiarising themselves with the building and some key health and safety elements but there was no guidance on how to undertake the role of a care worker and best practice information.

We recommend that the service finds out more about induction training for staff, based on current best practice.

Staff told us the level and range of on-going training they received kept them up to date with good practice. For example, moving and handling and dementia awareness. The registered manager had a program of regular training throughout the year, which was delivered face to face. However, there was the potential that newly employed staff would be required to wait nearly twelve months for some training because additional sessions were not delivered throughout the year. For example, a newly employed staff starting in March would be required to wait ten months for food hygiene training because this was only delivered once per year and had already been delivered in January 2018. We spoke with the registered manager about our concerns and they would review how training was delivered at the service.

People were cared for by staff that felt supported by the registered manager and staff told us they felt able to speak with the registered manager at any time for ask for guidance or support; however, one to one supervision for staff was not regular or consistent. The registered manager was unable to tell us what their own policy stated for the frequency of supervision meetings for staff but thought it was every three months. Records showed that some staff had not had a supervision meeting for eight months. The registered manager told us that supervision meetings had been planned for January 2018 but had yet to take place.

People were supported to eat and drink sufficient amounts to maintain a balanced diet. One person told us, "I have lovely food, absolutely no complaints from me." Another person said, "I love my food, I really look forward to meals and it is always tasty." Meals and drinks were arranged at set times of the day and although people were able to ask for drinks or snacks between the set times we observed that no drinks, snacks or fresh fruit were available to people to help themselves. People told us they enjoyed the food and we saw on the day of the inspection that it looked appetising; however there was no planned menu for people. The registered manager told us that they purchased food based on people's preferences and the registered manager decided what was going to be cooked each day. There was only one choice of main meal available; people were able to ask for something different if they did not like the option available. We discussed with the manager our observations in relation to choices available for people and drinks and snacks to be available so people could help themselves and maintain their independence. The registered manager advised they had listened to our feedback and would look at the concerns raised.

We spoke with the staff member who was cooking the main meal who displayed a good understanding about people's therapeutic diets, such as diabetic foods and the consistency of food people required. They

also knew people's dietary likes and dislikes. People told us they were able to eat their meals in their rooms if they wished to. One person told us, "I eat my main meal in the dining room but prefer to eat my tea in the room as I like to watch the quiz programs on the television."

People were supported to maintain their health and wellbeing and were supported to access health care services when they needed to. One staff member told us, "I wouldn't hesitate to call the GP if I thought someone was unwell." The Malnutrition Universal Screening Tool (MUST) was used to complete individual risk assessments in relation to assessing the risk of malnutrition and dehydration. This helped identify the level of risk and appropriate preventative measures. Fluid intake charts were used to record the amount of drinks a person was taking each day and intake goals and totals were recorded. All charts were well completed and analysed, which showed staff were effectively monitoring people's intake and taking action, as required.

People had access to a range of healthcare services. People told us that they had regular access to a GP. One person told us, "They [staff] have called a doctor for me today because my chest is a bit tight; I am waiting for the doctor to come." Referrals were made to specialist teams when required, for example, falls prevention teams. People had access to local GPs and an optician visited as required. People were supported to attend local dentists.

The premises met people's needs. People had access to a garden and a conservatory and were able to see their visitors in private. One person told us, "I like coming to sit in the conservatory and have a lovely view of the garden."

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. The service held an appropriate MCA policy and staff had been provided with training in this legislation.

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. DoLS applications had been submitted to the local authority and the service was working within the principles of the MCA.

People had consented to their care where they had the mental capacity to do so. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, and the policies and systems in the service supported this practice. We observed throughout the inspection that staff asked for people's consent before assisting them with any care or support. One person told us, "I always get lots of choice, I feel spoilt really." One relative told us, "[Person] is always treated with respect and is always asked about everything."

There was equality and diversity policy in place. Staff demonstrated that they were aware of their responsibility to help protect people from any type of discrimination and ensure people's rights were protected.

Requires Improvement

Is the service caring?

Our findings

People told us that staff treated them with dignity and respect. However, one person who shared a bedroom told us that they were supported with personal care at the bedroom sink while the other person was also in the bedroom and no privacy screens were in place, which was confirmed by the other person. This person told us that they were happy with the arrangements; however we were concerned that privacy screens were not being used in everyday practice and people's privacy and dignity was not always being respected.

We observed staff knocking on people's doors prior to entering, and ensuring that doors were closed whilst personal care tasks were being completed. One person commented, "I like to keep my door open but they [staff] still don't just walk in, they will always check first." A relative said, "They [staff] are great with [person]; I would soon know if [person] was not treated with respect because it would be the first thing they would have to say to me!" Staff were able to give appropriate examples regarding how they maintained people's dignity during personal care tasks.

There was a friendly and welcoming atmosphere around the home. People looked happy and relaxed and we observed positive relationships between people and staff. One person told us, "The staff are lovely, they are great. They can't do enough for you and I couldn't wish to be anywhere better." One relative said, "The staff are very friendly and accommodating." Throughout the day of the inspection, we observed family and friends welcomed as they visited their loved one. One relative said, "I am always offered drinks when I come to visit and I am always made to feel welcome."

Staff were able to tell us about people's individual needs, including their preferences, personal histories and how they wished to be supported. We found that staff worked hard to make people and their relatives feel cared for. Staff spoke positively about the people they supported, one member of staff said, "I love working here; everyone we care for has their own ways and we get to know them really well, like family really." People's individuality was respected and staff responded to people by their chosen name. In our conversations with staff, it was clear they knew people well and understood their individual needs.

People were actively involved in decisions about their care. One person told us, "I can choose when I want to get up and what I do throughout the day; I don't have to have a routine." If people were unable to make decisions themselves and had no relatives to support them, the provider had ensured that an advocate was sought to support them. An advocate is an independent person who can help people to understand their rights and choices and assist them to speak up about the service they receive. We spent time observing and listening to staff to see how they interacted with people they supported. We saw staff were attentive to people's needs and calls for assistance were answered promptly. The staff's approach was kind, caring and respectful.

Staff supported people to take pride in their appearance, people looked clean and well-dressed showing staff took time to support them. One relative said, "[Person] always looks clean and well looked after, it doesn't matter what time of day I visit it is always the same."

People were able to personalise their rooms according to their tastes and preferences. Some people had bought their own furniture with them, which made their rooms very homely. People were able to see personal and professional visitors in their personal rooms or in communal areas.

We looked at the arrangements in place to ensure equality and diversity and to support people in maintaining relationships. Relatives told us they were given regular updates about their relation and said they could visit and telephone the home at any time. One relative told us, "It has been a weight lifted off my shoulders finding a good care home where I can completely trust the staff to keep me informed." This showed the service supported people to maintain key relationships.

Good

Is the service responsive?

Our findings

People's needs were assessed before they moved into the home to determine if the service could meet their needs effectively. During the inspection, we saw records of preadmission assessments that had been carried out with people and their relatives. These covered areas such as medical history, mobility and nutrition and hydration needs. The preadmission assessment was used to devise care plans that provided staff with detailed information about how people should be supported.

Care plans were in place for people and were all accurate and up to date to reflect current care needs. The care plans were electronically stored and staff had access through a handheld device. The care plans were detailed and included current information about people's care needs as well as their social support needs and wishes. Records included information about how people's needs would be met. For example, end of life care, monitoring food and fluids and positioning charts for pressure care. All staff had access to the electronic care plans, which were password protected, and we observed, throughout the day, care staff inputting information on to care plans and monitoring charts.

The staff were responsive to people's needs and wishes. Most people were able to communicate with staff about their needs and wishes on a daily basis. People said they were able to make choices about what time they got up, when they went to bed and how they spent their day. One relative told us, "[Person] used to get up quite early when they first moved in, but now they are settled they often don't get up until a bit later." Another person told us, "I am able to do what I want all of the time; I have the best of both worlds. I can have a sleep in the afternoons and when I wake up my meal is ready."

Staff were made aware of any changes to people's care needs through regular handover of information meetings, during which, changes to people's care needs were discussed and staff updated. Staff used the information they received at handover to ensure that people received the care and support they required. We looked through the handover book and saw that there were regular updates in relation to people's changing health needs and staff had signed to say they had read the updated information.

Staff understood the need to support people's social and cultural diversities, values and beliefs. One person said, "I go to church regularly, sometimes if my friend can't take me the [registered manager] will take me because they know how important it is for me." The home had a variety of activities and staff told us there was usually something going on for people to do. People told us about arts and craft sessions, skittles, music sessions, exercise sessions and pet therapy. We saw different activities taking place during the inspection.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The provider was compliant with this standard. For example, there were easy read documents available for people.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Staff liaised with other agencies such as the palliative care nurses to support people with their final wishes. There were plans in place for the staff team to receive more detailed end of life training to enhance their skills.

People were aware that they could raise a concern about their care and there was written information provided on how to make a complaint. People told us that they had a good relationship with the staff and could discuss issues with them. One person said, "I've never had to complain about anything but I could speak to any of the staff or the manager [registered]." One relative said, "Honestly, I have never needed to discuss any concerns, I can't fault anything they [staff] do; they are always so caring and 'on the ball'."

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in place who was also the registered provider. 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 systems and processes in place to assess, monitor and manage the risks relating to the health, safety and welfare of people using the service required strengthening. Although the registered manager had some oversight of the service, there was not system of auditing and monitoring to ensure the providers own policies and procedures were being followed. For example, supervision for care staff was not in line with the providers own policy and supervision that had taken place was inconsistent. The induction process for new staff did not cover the minimum care standards that care workers are required to know to ensure they are able to meet people's needs. Infection control audits were also not in place.

Training records and the availability of training required improving. Although the registered manager had a training matrix for the mandatory training they offered, there was no record of other training that staff had received. The training opportunities for new staff required revising to ensure that they received the training they required to fulfil their role in a timely manner.

The processes in place for people to choose meals, drinks and snacks required enhancing to ensure people were able to have choices and maintain their independence.

The process of auditing of medicines required further improvement to ensure that all areas of medicine management are covered. At the time of the inspection, audits only contained information in relation to how much medicine was in stock. The frequency of staff competence checks to ensure that care staff are administering medications safely requires increasing. At the time of the inspection, competency assessments were carried out before staff were able to administer medicines but there was no process in place for this to continue.

The systems in place for obtained feedback from people who used the service, their relatives and other professional required improving. There was no formal process in place for obtaining people's views on the service. Relatives were able to share their views on a website and the registered manager used this feedback to ascertain the quality of the service. However, people and relatives did consistently tell us that they felt able to share their views with the registered manager. Feedback obtained from the website included, "The home is extremely clean and comfortable, all staff are approachable" and "This care home offers a very high standard of care."

The registered manager was in day-to-day contact with the service; people knew who the registered manager was and said they could approach them at any time. Staff told us the registered manager was approachable and supportive. One relative said, "[Registered manager] is very approachable, I wouldn't hesitate to speak with them if I wasn't happy about something, they always have time for us when we visit."

We talked to the staff about the ethos of the home. Staff were positive about the culture being open, with a 'home from home' atmosphere and supportive to each other. Staff told us they attended staff meetings and could share their views with the registered manager.

The registered manager worked in partnership with other organisations to improve the quality of the service. These included social services, district nurses and other healthcare professionals.

The Care Quality Commission (CQC) had been notified of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risks regarding Wendleberrie House.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider had on display the rating from the last inspection both in the service and also on their website.