Capstone Care Limited

Walshaw Hall

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

This was an unannounced inspection which took place on 26 and 27 July 2016. The service was last inspected on 29 July 2015 when we made some recommendations.

Walshaw Hall provides accommodation for up to 50 people who have personal care needs, including those with dementia. There were 33 people living in the service on the day of our inspection.

The service had a registered manager in place 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.

During this inspection all the people we spoke with told us they felt safe in the service. Staff had received training in safeguarding and were able to tell us how they would respond to any concerns. They were also aware of the whistleblowing policy.

Recruitment processes and systems in place within the service were robust. This meant that people who used the service were protected against the risk of unsuitable people working within the service.

Risk assessments were in place in relation to hazards in the environment. We found these were sufficiently robust to protect people.

Wheelchairs, hoists and moving and handling equipment had been serviced to ensure it was safe to use. Records showed that staff members had received training in moving and handling procedures.

The registered manager and staff members all felt there were enough staff on duty to meet the needs of people who used the service. We checked the rota which was a reflection on what we had been told on the day of our inspection.

Records we looked at showed that people had been assessed in relation to their capacity. These assessments had been undertaken by the relevant and appropriate people and had involved the person and their family. We also saw that best interest meetings had been undertaken for those people who lacked capacity to consent.

All the people we spoke with told us the food was good. We checked the kitchen and found adequate supplies of fresh, fresh, tinned and dried food was available. The service had a 5* rating from environmental health.

People who used the service told us that staff members respected their privacy and dignity and knocked on

their doors before entering.

Nobody in the service was receiving end of life care, however some staff members had undertaken training in this. All the staff we spoke with were able to tell us how they would care for someone at the end of their life.

Activities on offer within the service included, pamper afternoons, bingo with sherry and nibbles, singsongs, exercise sessions, greatest inventions of the times discussions, poetry corner and high tea with strawberries on Wimbledon Finals weekend. We observed a memory quiz was being held in one of the lounges.

Some care plans contained detailed information to guide staff on the care and support to be provided. However, some care plans we looked at lacked information and direction for staff members. We spoke with the registered manager and area manager regarding this. They told us the format of the care plans was still being trialled and that they were amending them when they felt improvements needed to or could be made.

People who used the service told us they were able to make their own choices such as what they wanted to eat, what they wanted to wear and how they wanted to spend their time.

Throughout our inspection we observed the registered manager interacted with people in a friendly and personalised manner. They knew the names of all the people who used the service and were able to speak in great detail about any of them.

Staff members we spoke with told us they would be happy for one of their relatives to use the service. They told us there was a good culture and the registered manager was very supportive of them.

The service undertook regular quality audits to highlight any improvements needed. We saw policies and procedures were in place to guide and direct staff in their roles.

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.

Staff were trained in safeguarding and knew their responsibilities in regards to reporting any concerns they had.

Medicines were managed safely in the service. Only staff who were trained to do so administered medicines to people who used the service.

Staff had access to personal protective equipment (PPE) which was available at various points throughout the service. We saw staff wearing PPE at times when they were providing personal care or serving meals.

Is the service effective?

Good

The service was effective.

New staff members had to undertake an induction which included mandatory training, shadowing a more experienced staff member and policies and procedures.

People who used the service had access to external healthcare professionals such as GP's, district nurses, dieticians and tissue viability nurses.

Communal areas were homely and nicely decorated. People's bedrooms were personalised with their own photographs, ornaments and furniture.

Is the service caring?

Good

The service was caring.

Apart from negative interactions from one staff member, the remainder of interactions we observed were kind, caring and sensitive to the needs of people who used the service.

We observed staff members encouraged people to remain as independent as possible, offering support as needed.

People's care records were stored confidentially and only people who needed to have access to them could.

Is the service responsive?

Good

The service was responsive.

We saw a range of activities were on offer on a daily basis. A new activities co-ordinator had been employed and was awaiting the necessary checks to be undertaken prior to commencing.

Pre-admission assessments were undertaken prior to anyone moving into Walshaw Hall to ensure the service could meet their needs.

Staff were able to tell us how they would respond if someone made a complaint to them.

Is the service well-led?

Good

The service was well-led.

People who used the service, their relatives and staff members felt the registered manager was approachable and had a very visible presence in the service.

Accidents or incidents that should be reported to CQC had been done in a timely manner.

Staff members had regular meetings where they were able to bring up items for discussion.

Walshaw Hall

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 26 and 27 July 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors on both days and an expert by experience on the first day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed the information we held about the service including notifications the provider had made to us. This helped to inform what areas we would focus on as part of our inspection. We had not requested the service to complete a provider information return (PIR) as we did not have time prior to the inspection; this is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

We contacted the Local Authority safeguarding team, the local commissioning team and the local Healthwatch organisation to obtain views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The local commissioning team informed us of concerns regarding the registered managers understanding of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA). Other concerns were raised about care plans not being updated, medication errors and documentation.

We spoke with five people who used the service and one relative. We also spoke with four staff members, the chef, the deputy manager and the registered manager.

During the inspection we carried out observations in all public areas of the home and undertook a Short

Observational Framework for Inspection (SOFI) during the lunchtime meal period. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care records for seven people who used the service and the medication records for a number of people. We also looked at a range of records relating to how the service was managed, these included training records, quality assurance systems and policies and procedures.

Good

Is the service safe?

Our findings

We asked people who used the service if they felt safe and free from bullying. Comments we received included, "Oh yes very safe. Every night I snuggle down in my bed and feel very safe knowing that there is always someone to call on if I need help", "Very safe. We have calls bells to alert staff if we need help" and "I feel very safe. Always people about to help us." None of the people and visitors we spoke with had ever witnessed any bullying.

Staff told us they had received training in safeguarding adults; this was confirmed by our review of staff training records. They were able to tell us of the correct action to take should they witness or suspect any abuse. Staff were also aware of their responsibilities to report poor practice and told us they were confident the registered manager would listen to them if they raised any concerns.

Two staff members we spoke with told us they were happy working in the service and had never seen anything that was a concern regarding safeguarding. Other staff members we spoke with told us, "I would be prepared to report any safeguarding issues to the registered manager or safeguarding", "I have not had to report any safeguarding issues. I would look for withdrawal, unexplained bruising, physical and mental", "I would look out for verbal abuse, physical abuse – anything that looked like abuse" and "I would pull a staff member to one side if I heard someone talking to someone in an offhand manner."

We observed that safeguarding information was also available in communal areas of the home for people who used the service, staff and visitors. This provided information on who to contact if anyone had any concerns in relation to the safety of people living at Walshaw Hall.

The service also had a whistleblowing policy in place which provided staff with a definition and the procedure they should follow if they needed to report poor practice. Staff we spoke with told us, "I am aware of the whistleblowing policy. Not had to use it but I would do if I felt I had to", "I am aware of the whistleblowing policy. If I needed to I would definitely report poor practice" and "I am aware of the whistleblowing policy and would be prepared to use it."

We looked at a number of operational risk assessments that were in place in the service including, falls from heights, hazardous substances, external walkways and security, boiler room, wet floors and moving and handling. All showed that consideration was given to how people might be harmed, what the service was doing to reduce the risk and any further action that was needed. This should help to ensure that people who used the service, staff members and visitors were protected against any risks within the service.

We found some of the risk assessments in place for people who used the service lacked information and actions to reduce risks. We spoke with the registered manager regarding this and they assured us they would action this by using the same format as the ones used for the operational risk assessments. This should ensure all the necessary information would be captured to mitigate risks to people's health and welfare.

We saw the service had a policy in place for the reporting and recording of all accidents and incidents within

the service. All necessary incidents had been reported to CQC in a timely manner. The registered manager ensured any falls that people who used the service had sustained were recorded on a monthly falls overview sheet. This showed any action taken to mitigate further risks of falls, such as close monitoring, pressure mats put in place or discussed with the falls team. We saw all accidents and incidents had been documented, although we could not see any evidence of learning from these or actions to be taken to mitigate further risks.

During our inspection we noted a number of wheelchairs, hoists and moving and handling equipment. We saw these were maintained and serviced on a regular basis to ensure they remained safe to use. We spoke with staff about moving and handling; they told us and records confirmed they had received training in moving and handling techniques. Comments we received included, "We get training on how to use the equipment in the home" and "I have had training with any equipment we use such as the hoists." One person we spoke with had completed train the trainer training for moving and handling, this allowed them to train other staff members in moving and handling techniques.

We saw that all the gas and electrical equipment had been serviced and checked within acceptable frequencies. This included electrical installations, gas appliances and portable electrical equipment.

We looked at fire safety within the service and found that personal emergency evacuation plans (PEEP's) were in place for all the people who used the service. These were detailed and included any mobility issues that needed to be considered, visual impairments, hearing difficulties and general information such as; how long it may take to evacuate the person. This should help to ensure that people are evacuated effectively in an emergency situation.

The service had a fire safety policy and procedure in place which detailed staff responsibilities, training, fire drills, the procedure in the event of a fire and general safety advice, for example not using the lift and not stopping to collect personal items. This was available in communal areas for people who used the service and any visitors. Records we looked at showed staff had received training in fire safety and had undertaken regular fire drills. We saw that fire escapes and fire systems were checked on a regular basis to ensure they were in good working order and fit for purpose. A fire risk assessment was in place.

The service had a contingency plan in place in case of emergency, including fire, flood, storms and technical or mechanical failures. Control measures were in place for staff to follow a three stage plan, ranging from what should be done within the first eight hours to three days. The contingency plan also identified the minimum amount of staff that should be on duty throughout a 24 hour period. This was made available in communal areas for people who used the service and any visitors.

We looked at the systems in place to ensure staff were safely recruited. We reviewed four staff personnel files. We saw that all of the files contained an application form, two references, and confirmation of the person's identity. We saw that the application form asked applicants to document a full employment history and to explain any gaps in their employment. Checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

People who used the service told us they thought there were enough staff on duty most of the time. Comments we received included, "Some residents wait a long time to be helped. Some residents told me they were waiting until 12pm one night last week to go to bed. They told me the next day when we met up for breakfast that they were very tired" and "I always sit in this chair and I have the cord for the call bell if someone falls or needs the toilet I have to press the bell because there is no one in the lounge with us. Some

people have to wait a long time and it's very distressing for them." One visitor told us, "Changeover at 8pm is bad; there is not enough staff on toilet duties. All the staff go into the dining room for handover, no staff in the lounge" and "Odd times at mealtimes people have to wait to be fed because they can't feed themselves, but on the whole if I need them they come quickly or as soon as they can."

We spoke with the registered manager regarding these comments. We were told that it was not possible to constantly have a staff member in each lounge (there are three in total on the ground floor); however two staff were always identified to be based in communal areas during handover times in case they are needed to support people. They also told us that staff handovers are undertaken in one of the lounges apart from 2pm when these are undertaken in the dining room. We did not observe that people had to wait a long time to be supported. Call bells were answered in reasonable time frames.

Staff members we spoke with all felt there was enough staff on duty to meet the needs of people using the service. Comments we received included, "The staffing levels are fine, we meet people's needs. There are times when we can cover the shift if people are off sick", "I think there are enough staff to meet people's needs and we work together as a team which helps. They try to get more staff in if someone is off sick" and "I think there are enough staff when they all turn up. We can call other staff in if we need to."

One visitor told us, "Staff don't make a point of talking with [relative's name]. If they could just have someone perhaps one hour a day to go round and chat to people. There is no personal touch." We asked staff members if they had time to sit and talk to people during their shift, without this being task led. Comments we received included, "We get time to sit and chat occasionally. I think there are enough staff to meet people's needs", "We get time to sit and chat to people. Activities are a good time to spend with people and you can have a good conversation with people when you give them care. Afternoons we interact with people more." We noted that staff did not sit and talk with people unless they were supporting them with a task.

On the day of our inspection we found a total of seven care staff on duty (including two senior care staff), three housekeepers, a maintenance person, two laundry assistants, one chef, two kitchen assistants, a dining room assistant and an administration person. We also noted an activities co-ordinator had recently been employed and was awaiting a start date in the near future. The registered manager and three deputy managers were also available to assist throughout the day if needed. We looked at the rotas for a two week period and found that staffing levels were similar to those on the day of our inspection. The registered manager also told us they were undertaking a recruitment drive in order to increase the amount of staff on nights from three to four.

We reviewed the systems in place to ensure the safe administration of medicines. One person we spoke with told us, "I always get my medicines on time." We saw that there was a policy and procedure in place to guide staff regarding the safe handling of medicines. This provided staff members with information about the management of medicines and included information on the storage, recording, disposal and ordering of medicines. This was kept with the medicines so staff could access this easily. Regular medicine audits were undertaken by the deputy manager and assessments of the competence of staff to administer medicines safely were undertaken on a six monthly basis. Patient information leaflets were available for some medicines although during our inspection a call was made to the pharmacist to request patient information leaflets for all medicines prescribed. The pharmacist confirmed they would attend the service to review which the service needed and to supply them. The service had a British National Formulary (BNF) to reference for possible side effects or contra-indications.

We saw those medicines that were required to be given before food were administered correctly, for

example the night staff would administer a medicine at 7am so people could have their breakfast on time. However this was not recorded as time specific on the Medicine Administration Record (MAR). The service contacted the pharmacist during our inspection to request improved labelling on medicines as they felt this would further safeguard correct administration of these medicines. We were also informed that the service would utilise the same forms as for 'as required' medicines so that the exact time of administration would be documented. Protocols were in place for those medicines which people were prescribed on an 'as required basis'. These protocols provided guidance and information for staff to help ensure people always received the medicines they needed.

We saw that there was a record of the temperatures where medicines were stored, including the fridge to ensure medicines were stored to manufacturers guidelines. There was a safe system for the disposal of unused medicines and sharp objects, for example, hypodermic needles.

Appropriate arrangements were in place in relation to obtaining medicines. We saw that sufficient stocks of medication were maintained to allow continuity of treatment. When a medicine was received into the home staff recorded the quantity received onto the MAR. Staff also recorded how much medicine had been brought forward from the previous month. This helped ensure that the medicines could be accounted for as the stock of medicines could be checked against the amount recorded as being given; thereby checking that people received their medicines as prescribed.

We checked to see that controlled drugs were safely managed. We found records relating to the administration of controlled drugs (medicines which are controlled under the Misuse of Drugs legislation) were signed by two staff members to confirm these drugs had been administered as prescribed; the practice of dual signatures is intended to protect people who use the service and staff from the risks associated with the misuse of certain medicines.

We noted all the Medication Administration Records (MAR) contained a photograph of the person for whom they were prescribed; this should help ensure medicines were given to the right person. Staff members recorded the times medicines were given and all entries were clear and legible.

We reviewed the systems in place to help ensure people were protected by the prevention and control of infection. We looked around all areas of the home and saw the bedrooms, dining room, lounges, bathrooms and toilets were clean. Our observations during the inspection showed staff used appropriate personal protective equipment (PPE) when carrying out tasks. Staff we spoke with demonstrated their awareness of their responsibilities to protect people from the risk of cross infection. Comments we received included, "I have had infection control training, including PPE and hand washing which are my responsibilities with infection control" and "I have had infection control training. We complete room checks to make sure they are clean and tidy." Staff had access to personal protective equipment such as gloves and aprons which were conveniently situated at various points throughout the service. We saw staff used the equipment when they needed to.

Lounges, bathrooms, toilets and people's bedrooms were clean and tidy throughout the service and we did not observe any offensive smells. There was a laundry which was sited away from food preparation areas. There were industrial type washing machines which had the facility to sluice clothes and other equipment, for example drying machines and irons to keep clothes freshly laundered. The service used colour coded bags to safely transfer and wash soiled linen. There was a system for bringing dirty laundry in and sending clean laundry out to prevent cross contamination. There were hand washing facilities in strategic areas for staff to use in order to prevent the spread of infection.

Good

Is the service effective?

Our findings

People who used the service told us they thought staff members were trained to meet their needs. We asked staff members if they felt they knew people well. Comments we received included, "I know the people I look after well. I know their individual habits. Most staff have been here for a while", "I think I know people well" and "I know the people I care for well." During our inspection we observed staff interactions and saw that they knew people who used the service well, including their likes and dislikes.

We looked at how staff were supported to develop their knowledge and skills, particularly in relation to the specific needs of people living at Walshaw Hall. We spoke with the manager, staff and examined training records to see what training opportunities had been made available.

Staff members were asked about their induction. One person told us, "I have done this job for years" and another person could not remember if they had done an induction. Other comments we received included, "I had an induction when I started my employment but it was not as good as it is now there is a different manager" and "I did basic training and shadowed for two weeks when I was on induction. I felt confident I could look after the people who lived here."

We saw that induction included an introduction to staff and service users, aims and objectives, staff handbook, policies and procedures, management arrangements, emergency and other contacts, role of CQC and other agencies, policy on gifts, visitors book, equal opportunities, mental capacity code of practice, smoking at work policy, codes of practice, tour of the building, security, fire procedures and drills, call bell system and safeguarding. New staff also spent time working alongside experienced members of the team until such time as the staff member felt confident enough to work independently. Records also showed that probationary reviews were undertaken at regular intervals to discuss how the staff member was progressing in their new role.

We asked staff members what training they had completed over the last 12 months. We were told, "We get plenty of training. Enough to do the job. I have done my NVQ three, safeguarding, moving and handling, infection control, health and safety, fire safety, first aid, food hygiene, palliative care, medicines administration, dementia care level two and mental health level two" and "Safeguarding, infection control, moving and handling, first aid, food hygiene, medication awareness, fire safety, health and safety, mental capacity and DoLS. I am also doing my National Vocational Qualification (NVQ) three."

We looked at the training matrix and saw the courses on offer for staff included diet and nutrition, safeguarding, moving and handling, first aid, fire safety, customer service, infection control, food hygiene, level two dementia, end of life care, medicines, mental health level two, NVQ level two and three, control of substances hazardous to health, equality and diversity, mental capacity act, DoLS, diabetes, health and safety, challenging behaviour and tissue viability. Some of these were mandatory courses that all staff had completed and some were optional courses for staff to further enhance their knowledge and skills if they wished or if it was recommended as part of their role.

Staff we spoke with told us they received regular supervisions and appraisals. Comments we received included, "I have supervisions and appraisals. I get the chance to bring up my training needs and other issues", "I have just had a supervision session. I brought up topics and training I wanted to do" and "I have had regular supervisions and appraisals. It is a two way process." Records we looked at showed that staff members had received supervisions on a regular basis and topics for discussion included training, team work, report writing, service provided to people, attention to detail, core values, attendance and employee feedback. We saw the registered manager used a matrix to remind her when staff were due their next supervision session.

We looked at what consideration the provider gave to 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.

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 saw the service had policies and procedures relating to the MCA and DoLS. These looked at restrictive practices, principles, assessments and best interests of people who used the service. Staff told us and records showed that staff members had received training in MCA and DoLS. One staff member told us, "I have had MCA and DoLS training. In the main it is about meeting people's needs in the least restrictive way. We get outside agencies to give us an independent view."

Records we looked at showed that people had been assessed in relation to their capacity. These assessments had been undertaken by the relevant and appropriate people and had involved the person and their family. We also saw that best interest meetings had been undertaken for those people who lacked capacity to consent. A 'best interest' meeting is where other professionals, and family if relevant, decide the best course of action to take to ensure the best outcome for the person using the service. We saw that the service had involved external health professionals in their decision making process and acted in the best interest of the person being assessed. Those people that had capacity had consented to the care and treatment being delivered.

Prior to our inspection we reviewed our records and saw that DoLS applications, which CQC should be made aware of, had been notified to us in a timely manner. We saw information to show that authorisations to deprive people of their liberty had been made to the relevant supervisory body (local authority).

The care records showed that people had access to external health and social care professionals such as, hospital consultants, GP's, district nurses, specialist nurses, dentists, opticians and chiropodists. This meant that the service was effective in promoting and protecting the health and well-being of people who used the service.

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. We looked at the kitchen and food storage areas and spoke with kitchen staff.

During the lunchtime meal service on both days of our inspection, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We found the lunch time meal service was a relaxed occasion. Tables were laid with linen napkins, condiments, flowers and music was playing on the radio whilst people were chatting amongst themselves.

We saw staff members were supporting those people who needed assistance, giving them time to eat their meals without being rushed. People were given choices of food; we saw one person requested a salad and this was granted. We observed one person had two main courses and two puddings on the first day of our inspection and on the second day of our inspection we noted that staff members asked everyone if they wanted more. People were asked if they wanted tea, coffee or juice during their lunch. Fresh fruit was also available on a table for people to help themselves to.

All the people we spoke with who used the service told us the food was good. Comments we received included, "The food is good", "Yes it is nice" and "It was lovely." One visitor we spoke with also commented that the food was good. We did not see any jugs of water/juice in communal areas or bedrooms for people to help themselves to if they were thirsty; however people told us they had access to drinks and snacks throughout the day and could ask for a hot drink at any time.

Staff members we spoke with told us, "I get time to spend with people during their dining experience. I try to encourage people such as eating independently", "We look at what people are eating and put people on a chart if necessary to monitor nutrition" and "We get time to help people take a reasonable meal and document it when they don't. We give them an extra pudding if they will not touch the main meal." Records we looked at showed food and fluid charts were completed for those people at risk of malnutrition. These records were detailed and contained information on the amount of food people had consumed, for example half a portion, so this could bme effectively monitored.

The service had recently employed a new chef. We observed they were serving the meal at lunchtimes and after people had eaten they went around and asked everyone if they had enjoyed what they had just eaten. All the people spoken to told them they had enjoyed their lunch. We also observed the chef asking people for suggestions of what they would like on the menu.

We found the kitchen was clean and well organised with sufficient fresh, frozen, tinned and dried food stocks available. We saw records were completed in relation to temperature checks, cleaning schedules and meals served each day. The cook was aware of people's dietary needs and how to fortify foods to improve a person's nutrition.

The environmental health department had given the kitchen a five star very good rating at their last inspection. This meant the kitchen staff followed safe practices around the storage and preparation of food.

During the inspection we conducted a tour of the building. We saw there was an on-going program to redecorate the home as bedrooms became empty. All the bedrooms we visited had been personalised to people's own tastes and people could bring in their own furniture if they wished.

The communal areas were homely and there was a variety of seating to suit all tastes. There were three lounges and people could sit where they liked and we saw people chatting to each other or watching television.

The outside space had recently been improved. This included a patio area where people could sit and enjoy

the weather and the view or have their meals. This was an enclosed safe area which meant that people living with dementia could also access outdoor space.

Bathrooms and toilets had equipment to aid people with a disability and people had a choice of shower or bath. There were lifts to help people access all areas of the home.

Good

Is the service caring?

Our findings

People who used the service told us they were well cared for by staff that were caring. Comments we received included, "All the staff are lovely and very helpful", "All the staff are really kind", "They are so kind. When I have a bath or shower they chat to me all the time, dry me off in-between my toes and put talc on me. It's lovely", "Staff are nice", "Staff are lovely" and "Yes, the staff are kind."

Staff members we spoke to about their role told us, "I have a passion for old people that is why I enjoy working with them. I genuinely like caring for older people", "I like working here. I like all the residents, I love all the residents", "I enjoy being in this type of surroundings and helping the elderly. I get a kick from them telling me they are pleased with how I have helped them", "It is a happy home. There is a very good staff team. I like the people who live here. I love supporting people" and "We all get on. It is a good staff team. It is a happy home but there can be stressful days."

We found it necessary during our inspection to speak to the registered manager regarding a member of staff whose tone of voice towards a number of people was brusque. Both inspectors and the expert by experience had observed their interactions and agreed their tone of voice when supporting people was questionable. The registered manager told us they would address this as a matter of urgency. However, we mainly observed care and interactions from staff members that were kind, caring and sensitive. We overheard a conversation from a staff member who was assisting someone in a bathroom (the staff member was not aware we could hear the conversation). This staff member spoke to the person in a calm and reassuring manner, offering patience and understanding. We observed staff members did not rush people when they were supporting them, for example giving people time to eat their meals.

People who used the service told us that all staff members respected their privacy and dignity when assisting them with personal care and that they knocked on their doors before entering, although did not always wait for an answer before entering.

We noted that all care records were stored securely; this helped to ensure that the confidentiality of people who used the service was maintained.

We asked staff members how they supported people to remain independent. One staff member told us, "We help one lady to be mobile; we support her to walk independently." We observed throughout the day that staff members encouraged people to walk for short distances and to eat their own meals as much as possible without support. However, support would be given at times when people either requested it or staff observed that people needed it.

We saw that an advocacy service was advertised in communal areas for those people who may have wished to have one. We did not see any evidence during our inspection that anyone had an advocate.

Although nobody within the service was currently receiving end of life care we saw that some staff had received training on this. One staff member told us, "We do not have anybody on end of life care but if we

did I would make sure we adhered to what they wanted and get all they want; respect their wishes." Another staff member told us, "I have had end of life training but it was some time ago. I would get district nurses involved to see if they needed an air mattress, delegate one member of staff to look after them, look after their medication needs and assess if they are in pain." One staff member who had not completed training in end of life told us, "I want to complete palliative care training and they will arrange it when I am a senior."

Good

Is the service responsive?

Our findings

The previous activities co-ordinator no longer worked in the service. The registered manager told us they had recruited a new activities co-ordinator and were awaiting all the necessary security checks to be completed before they commenced; they anticipated this would be in August 2016. Records we looked at showed that two staff members were identified daily to undertake the activities until such time as the activities co-ordinator commenced employment.

One staff member told us, "We all get turns in doing activities with people. I like to do pamper sessions and talking about the past and great inventions like the wheel. They really get into it"

We looked at the notice board in the entrance of the service and saw a weekly activity plan. Activities on offer included, pamper afternoons, bingo with sherry and nibbles, singsongs, exercise sessions, greatest inventions of the times discussions, poetry corner, karaoke, international jokes day, battle of Somme remembrance service, draughts, dominoes, book club, fruity Friday (guessing the unusual exotic fruits from around the world) and high tea with strawberries on Wimbledon Finals weekend. On the first day of our inspection we observed a memory quiz was being held in one of the lounges.

People who used the service told us they did go on trips and outings on occasions and that most days activities were on offer. We saw that every month an external trip was undertaken entitled "Singing for the brain" which was held in a local community centre. The registered manager told us this was provided within the service for those people who did not wish to go out.

We noted that the pastoral needs of people who used the service were catered for by the Reverend from the local church who held a church service every month in Walshaw Hall and a catholic priest attended once a week to administer Holy Communion to those people who wished to partake.

Records we looked at showed that prior to moving into Walshaw Hall a pre-admission assessment was undertaken. This provided the registered manager and staff with the information required to assess if Walshaw Hall could meet the needs of people being referred to the service prior to them moving in.

We looked at the care records for seven people who used the service. Some care plans contained detailed information to guide staff on the care and support to be provided. There was good information about the person's social and personal care needs. People's likes, dislikes, preferences and routines had been incorporated into their care plans. This showed a person-centred approach to providing care. However, some care plans we looked at lacked information and direction for staff members. We spoke with the registered manager and area manager regarding this. They told us the format of the care plans was still being trialled and that they were amending them when they felt improvements needed to or could be made. We were reassured that the issues we found would be addressed.

Three people who used the service that we spoke with told us that although they had never needed to make a complaint they were unhappy that they had to access The Beeches (the provider's new service next door

to Walshaw Hall) in order to attend the hairdressers. They told us they had to go outside in 'all weathers' and if it was raining their hair would get wet. We spoke with the registered manager regarding this. They informed us that the service was addressing this issue with the installation of a cover over the walkway between the two buildings in the near future.

Staff we spoke with were able to tell us what they would do if anyone complained to them. One person told us, "I have not had to deal with a complaint. I would pass on any concerns to a senior staff."

People who used the service told us they were able to make their own choices such as, if they wanted to eat their meals in their bedroom, if they wanted their doors open or closed, what they wanted to wear and what they wanted to eat.

We spoke with staff members to ask them how they gave people choices. Comments we received included, "We give choice in all that we do, what they want to wear, what they want to do", "When I give medication they have the right to refuse it. Meals are another choice", "When we get people up we give choices about their clothes. They also have choices at meal times. People are reminded of their options", "People can stay in bed if they like" and "We leave people if they do not want to get up."

Good

Is the service well-led?

Our findings

The service had a registered manager in place 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.

All the people we spoke with who used the service and their relatives knew who the registered manager was. All of them thought the registered manager had a very visible presence in the service and felt confident and happy to approach them with any concerns or problems they may have.

Staff members we spoke with told us the registered manager was approachable and fair. Comments we received included, "The manager is approachable and fair. I think I can raise anything with her and there is also the area manager", "The registered manager is very supportive. She is brilliant. She has improved the service. We get a lot more support", "You can talk to the manager and she is approachable. You get support from her. You can even get hold of her outside working hours if you need to" and "I think the manager is good to work for."

Throughout our inspection we observed the registered manager interacted with people in a friendly and personalised manner. They knew the names of all the people who used the service and were able to speak in great detail about any of them.

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

We looked at the quality assurance systems in place within the service and found that these were sufficiently robust to identify areas for improvement. The audits we looked at included medicines, complaints, maintenance, risk assessments, policies and procedures, appraisals and supervisions, fire safety, health and safety, cleaning and kitchen. All of which were undertaken on a regular basis.

There were policies and procedures for staff to follow good practice. We looked at several policies and procedures which included accidents reporting and recording, management of aggression, complaints, confidentiality, consent, DoLS, fall prevention, fire safety, hand washing, MCA, recruitment, whistleblowing, supervision and safeguarding. These were accessible for staff and provided them with guidance to undertake their role and duties.

People who used the service told us they liked living at Walshaw Hall. Comments we received included, "I like living here. I have been here for five years, it is my home."

Staff members we spoke with told us, "There is a good culture here. I do think you can raise anything with

the manager. They are supportive" and ""There is a good management team. Staff are aware of who to go to if they need anything." All the staff members we spoke with told us they would be happy for one of their relatives to use the service. Comments we received included, "I would be happy for one of my relatives to live here. It is one of the best homes I have worked in for choice and team work" and "I would be happy for a member of my family to live here."

Records we looked at showed the service had received compliments from people who had used the service or their relatives. Comments we saw included, "Many, many thanks for the care you gave [name of relative]. My relative has been in the home for three years. During this time if there have been any health issues the local GP and family are informed. We visit every day and have never found anything amiss", "[Name of person] has been treated as an individual. Care and attention is very good and [name of person] is happier here than she was at home" and "The staff show [name of person] much affection and support. This is now her home and those who care for her – her friends. There are opportunities for fun and companionship and the food is excellent."

The registered manager told us they sent out questionnaires to relatives as a means of gaining feedback about the service. We saw that the results of the questionnaires sent out in November 2015 had been collated. 37 questionnaires had been sent out and 27 had been returned. 100% felt the home provided a good quality environment, 95.8% felt cared for by the staff, 95.8% felt they had the opportunity to express their views about the service, 100% were satisfied with the meals provided by the service, 91.6% felt that comments, suggestions and complaints about the service were listened to and 100% were satisfied the service provided was good quality. We saw the registered manager had provided a response to the outcomes and detailed how improvements would be made, for example; the service user guide was re-issued to everyone, a range of alternative meals was always available and a reminder that people can approach the staff at any time if they have a concern.

Records we looked at showed that staff meetings were held on a regular basis. Staff we spoke with told us, "I get the chance to have my say at meetings" and "I can bring up what I like at staff meetings. We also have senior meetings." We saw items for discussion included, people who used the service, clocking in, holiday requests, hair salon, kitchen, general topics and handovers.

We saw that residents meetings were held on a monthly basis. Records showed that areas for discussion included, activities, food, laundry, care and any other business. We saw that things had changed as a result of these meetings, such as a cover was being considered for the walkway between the two buildings for when people were attending the hairdressers (to keep them dry if it was raining) and someone had requested Whinberry pie for tea which had been added to the menu.