Tricuro Ltd

Wallfield

Inspection report

29 Castlemain Avenue
Southbourne
Bournemouth
Dorset
BH6 5EJ

Date of inspection visit:
29 May 2018
30 May 2018

Date of publication:
11 July 2018

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 comprehensive inspection took place on 29 and 30 May 2018. The first day was unannounced.

Wallfield 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.

The provider, Tricuro Ltd, is owned by the local authorities for Bournemouth, Dorset and Poole. Wallfield was previously run by Bournemouth Borough Council.

Wallfield accommodates up to 14 people in individual bedrooms on the ground and first floors of an adapted building. The two floors are connected by stairs and a passenger lift. There were 13 people there at the time of our inspection.

Wallfield was registered prior to the publication of Registering the Right Support. It reflects the values that underpin Registering the Right Support and other best practice guidance, except that it is larger than this guidance recommends. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The registered manager had worked at the service for a number of years. 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 service had a friendly, homely feel. People were treated with kindness, respect and compassion, and their privacy and dignity was upheld. People knew and felt comfortable with staff.

People felt safe and were protected from neglect and abuse. Risks were assessed and people were supported to stay safe with the least possible restriction on their freedom. There were pre-employment checks to ensure candidates were suitable to work in a care setting.

People's physical, mental health and social needs were assessed holistically, and care and support was planned and delivered in a personalised way to meet those needs. People, and where appropriate their families, were involved in decisions about their care and support. People who were able to speak told us they were happy with their care and support. The registered manager and staff kept abreast of good practice through attending training and discussing developments in good practice at team meetings and during supervision. Staff had training in equality, diversity and human rights to help them challenge and avoid discrimination.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005.

People and their relatives were encouraged to be involved in decisions about care.

Relatives and friends could visit when they wished without notice.

There were links with the local community.

People had ample access to meaningful activities and were encouraged to follow interests and hobbies.

People made choices about what they ate and drank. Mealtimes were relaxed and sociable occasions, with people receiving the support they needed to eat and drink at their own pace. Dietary needs were clearly accounted for in people's support plans and referrals pursued to dieticians or speech and language therapists as appropriate.

People were supported to manage their health and had access to healthcare services as they needed. They each had a 'health passport' to provide to hospital staff in the event they needed treatment there.

There were sufficient appropriately trained staff on duty to support people in a person-centred way. There had recently been a recruitment freeze, but the service was now recruiting support workers again. The service used regular agency staff, whom people knew, to fill any gaps in the rota.

Staff were supported through training, supervision and appraisal to perform their roles effectively.

Staff were valued, respected and supported. Their voices were heard and acted upon to develop the service, through supervision, team meetings and ad hoc conversations with the management team. The service was open to the concerns of staff, whether through whistleblowing, supervision and staff meetings, or staff surveys.

Accidents, incidents or near misses were recorded and monitored for developing trends.

The premises were clean and well maintained. Individual bedrooms were furnished and decorated according to people's preferences.

People were protected from the spread of infection.

Medicines were stored securely and managed safely. We have made a recommendation in relation to handwritten medicines administration records.

The service sought to support people to have a comfortable and dignified death when the time came. The service was working towards accreditation with a nationally recognised scheme that promotes a high standard of end of life care. The manager and staff sought to establish end of life preferences in a sensitive way with people and their families.

Clear information about how to make a complaint was available for people. Complaints were taken seriously and investigated openly and thoroughly.

Care records had been transferred to a computer system. Each staff member had password access to the system and left an electronic footprint whenever they looked at someone's records. The service had audited its data protection procedures earlier in the year, in view of imminent changes to the data protection legislation.

The service worked in partnership with health and social care professionals and other organisations, to ensure people's care needs were met and that staff kept up with good practice in supporting people with a learning disability.

The provider had quality assurance processes in place, which helped to maintain standards and drive improvement.

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 were protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination.

Risks were assessed and managed in the least restrictive way possible.

There were enough competent, safely recruited staff to provide care and support in a person-centred way.

Is the service effective?

Good

The service was effective.

Staff were supported to maintain the skills and knowledge they needed to carry out their roles.

People had a choice of food and had access to sufficient food and drink throughout the day. Meal times were are not rushed and there were enough staff to provide support at people's own pace, if needed.

People had the support they needed to maintain their health.

Is the service caring?

Good

The service was caring.

People were treated with dignity, respect and kindness. Their privacy and dignity was upheld

People had positive relationships with staff, who knew and understood them.

Is the service responsive?

Good

The service was responsive.

People and, where appropriate, their families were meaningfully involved in developing their support plans.

Staff enabled people to carry out person-centred activities and encouraged them to maintain hobbies and interests.

The service dealt with complaints in an open and transparent way. Complaints and concerns were explored thoroughly and responded to in good time.

Is the service well-led?

Good

The service was well led.

The service had a positive, person-centred, open and inclusive culture. Leaders and managers shape this culture by engaging with staff, people who use services, carers and other stakeholders.

Leaders and managers were available, consistent, and lead by example.

Staff understood their role and responsibilities, were motivated, and had confidence in their leaders and managers.

Wallfield

Detailed findings

Background to this inspection

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

The inspection was prompted in part by information of concern about some people's care, which we referred to the local authority safeguarding team. We used this information to plan what we would examine during this inspection.

The inspection took place on 29 and 30 May 2018. The first day was unannounced. The inspection team comprised two adult social care inspectors and an expert by experience on the first day, with the lead inspector returning alone on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information CQC held about the service. This included notifications about significant events and a Provider Information Return (PIR). A PIR 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 also obtained feedback from a health and social care professional.

During the inspection we met most of the people who used the service and spoke with four of them. We also spoke with five staff, including an agency worker, and the registered manager. We made observations around the service and reviewed paper and electronic records. These included four people's care records, five staff files and records relating to the management of the service, including complaints and compliments, quality assurance records and records relating to the upkeep of the premises and equipment.

Good

Is the service safe?

Our findings

People were protected from neglect and abuse. People told us they felt safe. Comments included: "I feel safe here, I like it here. The staff are nice – all of them" and "We've got nice ones [staff]." There were posters in communal areas with information about how to report suspected abuse. Keeping safe was discussed at house meetings, and safeguarding featured on agendas for staff supervision and team meetings. Staff had training in relation to safeguarding adults and understood how to report concerns.

Risks were assessed and people were supported to stay safe with the least possible restriction on their freedom. Risk assessments were individualised according to people's individual circumstances. These were regularly reviewed and were also updated if there had been a change in someone's circumstances. They covered areas such as malnutrition, vulnerability to pressure sores, moving and handling, falling, choking, and hazards associated with activities at Wallfield and in the community.

The premises were maintained in a clean and orderly condition. The appropriate certification was in place for gas, electrical wiring, portable electrical appliance testing and safety of lifting equipment. Precautions were taken against the growth of legionella bacteria, which can cause serious illness, in the water system. Fire equipment and signage was in place. People had personal emergency evacuation plans, which were readily available in one place in the event emergency services needed to attend.

Accidents, incidents or near misses were recorded and monitored for developing trends. A member of the management team checked each one to ensure all necessary action had been taken to keep people safe. Where any injury had occurred, there was additional oversight by the local authority health and safety team. Accidents and incidents were collated and analysed within the service and at provider level, to identify any trends that might be developing.

There were sufficient staff on duty to support people to stay safe and meet their needs, although the service relied on relief and agency staff to cover gaps in the rota as there had been five staff vacancies for some time. A person who lived at the service told us, "There's enough staff and they are well trained." Staff had essential training and annual competency checks in safety systems and processes, such as moving and handling people and handling medicines. Staff who worked permanently or occasionally in senior support worker and managerial roles had training to equip them, and the registered manager checked their understanding before they took on these responsibilities.

Safety was promoted through the provider's recruitment processes. Pre-employment checks were completed prior to staff starting work. These included obtaining and verifying references, a full employment history with reasons for leaving posts and details of qualifications in health and social care. Enhanced criminal records and barred list checks were made with the Disclosure and Barring Service.

Medicines were managed and administered safely. They were stored securely. People were involved as far as safely possible in managing their own medicines. For example, one person applied their own skin creams and some people popped their own medicines out of blister packs, under staff supervision. People's

medicines administration records (MAR) and medication support plans contained clear guidance for staff about when and how each medicine should be administered. This included 'as necessary' medicines such as painkillers. In the current month's MAR, staff had initialled against all doses of medicines that were due. Most MAR were pre-printed by the pharmacy. Others had been transcribed by staff based on directions from prescribers. The provider's procedure was for handwritten MAR to be checked and countersigned as correct. However, some had not been countersigned as they should have been, although the instructions were correct. We drew this to the attention of the registered manager.

We recommend the service reviews its procedures for transcribing MAR to ensure these are always checked and countersigned as correct.

People were protected from the spread of infection. Staff had training in infection prevention and control and food hygiene. The service had gained a five star (very good) food hygiene rating earlier in 2018. There were handwashing facilities in toilets and bathrooms, the kitchen and the laundry. Personal protective equipment, such as disposable gloves and aprons, was readily available where it was needed, such as in the laundry. The laundry was clean and tidy, with a clear dirty-to-clean workflow separating clean and dirty linen.

Good

Is the service effective?

Our findings

People's physical, mental health and social needs were assessed holistically, and care and support was planned and delivered in a personalised way to meet those needs. The registered manager and staff kept abreast of good practice through attending training and discussing developments in good practice at team meetings and during supervision. Staff had training in equality, diversity and human rights to help them challenge and avoid discrimination.

Staff had the skills, knowledge, experience and support to perform their roles effectively. They were supported through training, supervision and appraisal to do so. Staff had the training they needed when they first started working at the service. This induction training was based on the Care Certificate, which covers a nationally agreed set of standards expected of workers in health and social care. It covered topics such as moving and handling, health and safety, infection control, safeguarding awareness, and equality, dignity and human rights. This training was refreshed at one, two or three-yearly intervals thereafter. Supervision with line managers took place at least every three months with an annual appraisal to review performance and discuss training needs.

People were involved in decisions about what they ate and drank. They were positive about the food; comments included: "The food is really nice, I've got fish pie tonight; fish pie is my favourite… I get two choices. I have smoked fish for tea, they know I don't like curry", "I love curry, I eat it all the time, I'm having curry tonight. It's all very good here" and "I get nice food, fish and chips but I've got to watch my diabetes… I think they watch my diet here". People were supported to have a balanced diet, whilst their preferences were respected. There were discussions about menus at house meetings, to ensure menus included people's preferred items. Menu options were presented at mealtimes, with a pictorial menu on display in the dining room. If people preferred not to have what was on the menu, they could request a light bite alternative, such as an omelette or a jacket potato. Mealtimes were relaxed and sociable occasions, with people receiving the support they needed to eat and drink at their own pace.

Dietary needs were clearly accounted for in people's support plans. Where there were concerns about people having difficulty swallowing, staff sought referrals to a speech and language therapist for a swallowing assessment. For some people, speech and language therapists had devised safe swallow plans that set out how foods should be presented and the support needed when eating and drinking, to reduce these risks. Each time they assisted someone who had a safe swallow plan to eat and drink, staff recorded that they had read the guidelines. Similarly, if there were concerns about risk of malnutrition, referrals were sought to a dietitian. Those people who were above the ideal weight for their height had the capacity to make decisions themselves about whether to lose weight or have a healthy diet, and these were respected.

People were supported to manage their health and have access to healthcare services as they needed. When there had been concerns about people's health, these were referred promptly to the relevant health professionals. People discussed the support they needed to manage their health with their key worker and trusted members of staff. Someone told us how they tended to get anxious and were trying strategies to manage this. Staff were conscious of the person's anxieties and of tailoring their interactions accordingly.

Someone else sometimes called the doctor independently, and during the inspection staff took a call from the surgery to clarify whether the person needed a home visit. Staff went to discuss this with the person and agreed how they would support the person to monitor their concerns.

The service sought to work together with other services to deliver effective care and support. People each had a 'health passport' to provide to hospital staff in the event they needed treatment there. This summarised important information about them, their health needs, and how they communicated. Some people came to the service for short-term respite rather than staying there permanently. The service liaised with their families and social care professionals to make the appropriate arrangements.

Individual bedrooms were furnished and decorated according to people's preferences. A person told us about their room: "I've got a nice room, I picked the colour and I've got a new carpet. I picked every piece of furniture here. All the staff say it's the best room in the house. I've got pictures and photos." Some rooms were adapted for people with mobility difficulties, with overhead tracker hoists. Bedrooms were labelled with names and photographs. Toilets and bathrooms were also clearly identifiable. Toilets and bathrooms had adaptations for people with mobility difficulties, such as grab rails and a lifting bath. Sensory equipment had been installed in one bathroom, to help people feel relaxed during personal care, which can be stressful for people. There was a lounge with a television and a smaller quiet lounge. Internet access was available to people through Wi-Fi. Outside was a large garden with a summer house; some people particularly liked to spend time outside.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005. 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 the least restrictive possible. Where people were able to consent to their care, staff obtained their consent. If there was concern that a person might not understand the decision to be made, their mental capacity to make this decision was assessed. If they were found to lack capacity, staff made a best interests decision about how to provide the necessary care in the least restrictive way possible. They consulted key people in the person's circle of support, such as family members and health and social care professionals, in reaching these decisions. Examples of best interest decisions related to medication, receiving care and holding money.

People can only be deprived of their liberty so that they can 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). The registered manager had identified a number of people who they believed were being deprived of their liberty, as the front door was kept locked and people were unable to leave unsupervised for their own safety. DoLS applications had been made to the relevant supervisory body before existing DoLS authorisations had expired. There was a system for tracking expiry dates and any conditions on DoLS authorisations.

Good

Is the service caring?

Our findings

People were treated with kindness, respect and compassion. All of the interactions we observed throughout the inspection demonstrated this. People responded as if this was normal and natural, in line with their usual experience. This respectful and compassionate approach was echoed when staff spoke about people with each other and with us. Staff were alert to when people where anxious or distressed and acted quickly and calmly to support them. People told us, "Somebody would come if I needed help" and "They always come to help me."

People knew and felt comfortable with staff. They told us: "I like them all here, they're all kind and funny, they make me laugh" and "They are caring". People readily approached staff to talk or interact with them. Many of the staff had worked at the service for at least a couple of years and had a good understanding of people, their personal backgrounds and histories, their interests and preferences and how they communicated. Some people used unique sounds and gestures to communicate, rather than words, and staff had a good understanding of what they were saying.

People and their relatives were encouraged to be involved in decisions about care. They had regular informal discussions with people's key workers and were central to care planning meetings. Information about advocacy services was available for people and staff, and people had had contact with advocates where needed. Relatives and friends could visit when they wished without notice.

People's privacy and dignity was upheld. Assistance with personal care was offered discreetly where needed and took place behind closed doors. Staff knocked doors before entering people's rooms. A person told us how someone who previously lived there used to come into their room and pinch things, "so I have a lock on my door now".

Care records had been transferred to a computer system. Each staff member had password access to the system and left an electronic footprint whenever they looked at someone's records. The service had audited its data protection procedures earlier in the year, in view of imminent changes to the data protection legislation.

Good

Is the service responsive?

Our findings

People, and where appropriate their families, were involved in planning their care and support. People who were able to speak told us they were happy with their care and support. For example, people said, "The Manager is very nice and all the staff and they always help" and, "It was my birthday yesterday, they gave me a cake. They look after me here." Those who did not speak all looked happy and relaxed with staff, who communicated with them in a positive and caring way. Comprehensive, up-to-date support plans were individualised to the person according to their needs and preferences. These included information about people's goals, aspirations and life histories and reflected their preferences. Support plans promoted people's independence and what they could do for themselves. They covered areas including communication, personal care, eating and drinking, cultural and spiritual needs, health conditions and staying safe. People also had health passports that described in a clear and straightforward way the support they needed to manage their health. The registered manager and staff had a good understanding of people's individual care and support needs.

There was an emphasis on meaningful activity and following interests. People told us: "I got fed up with gardening so I do mosaics and glass painting", "I used to go to the Tuesday club but it's too noisy for me. I go on trips out or a pub meal" and, "I like writing and painting. People come every Thursday and we do painting; it's a bit like the day centre but it's at home." People went out and about during the inspection. Some opted to go with others to Tuesday Club or to go and buy a chip shop lunch, which was an activity that people had decided on. People also went out individually when they wanted to, for example going shopping or for individual activities. In addition, people were involved in routine personal tasks with support from staff, such as doing their laundry and cleaning their room. There was a strong sense of people getting on with their daily lives and staff supporting them to do so, rather than people fitting into routines determined by staff.

The service met the Accessible Information Standard, which became law in 2016 to make sure people with a disability or sensory loss are given information in a way they can understand. People's communication needs and sensory impairments were flagged up in their support plans and health passports. Staff adapted their communication according to people's needs. Someone living at the service had a visual impairment and staff gave them the support they needed to live a full life.

The service sought to support people to have a comfortable and dignified death when the time came. No-one at the service was at the end of their life during the inspection. However, two people had died of natural causes since the last inspection. Staff had worked with GPs and district nurses to ensure the person had the care they needed. They monitored staff interactions with the person as they were approaching death, to ensure the person was getting the practical and emotional support they needed. The service was working towards accreditation with a nationally recognised scheme that promotes a high standard of end of life care. The manager and staff sought to establish end of life preferences in a sensitive way with people and their families. For example, they used opportunities when people talked about the most recent death at the service and the funeral, to establish people's preferences.

Clear information about how to make a complaint was available for people. There had been one formal complaint in the past year. The person had discussed some grumbles with staff and decided to make a formal complaint. They had the support they needed to do so. The registered manager responded promptly to this, investigating thoroughly and upholding the complaint. They had agreed a course of action with the person, and the person told us they were pleased with this.

Good

Is the service well-led?

Our findings

The service had a friendly, homely feel despite being based in a large building with features of a care home such as noticeboards, fire extinguishers and health and safety signage. This was evident in the way people and staff interacted with each other. For example, an administrative worker sat and ate their packed lunch opposite a person who was eating alone and they chatted easily about the hot weather and how the person felt better after having a nap. Most staff had worked at Wallfield for a long time. They were positive and proud about working at there. Comments included: "I love it here, it's a really great place to work, it's like home", "I love it because the residents are the focus… It really is a nice place to work – not many people come and go" and "The staff retention rate is good; people tend to stay."

People were involved in decisions about life at Wallfield. Aside from informal chats with the registered manager and staff, the main forum for this was regular house meetings. Easy-to-read agendas and meeting notes were provided to people. Meetings obtained people's views and made decisions on matters such as menus, activities and holidays, as well giving news updates about the service.

Staff were valued, respected and supported. Their voices were heard and acted upon to develop the service, through supervision, team meetings and ad hoc conversations with the management team. The registered manager and senior staff were available and approachable to the team throughout the inspection. This was reflected in staff comments, for example, "[Registered manager] is really supportive. You can always ask her questions, even though she has two services. I feel very supported here", "We all support each other" and "[The registered manager and deputy] are supportive in every aspect, there's an open door policy… The company had a recruitment halt which did have a little bit of impact [on morale]. A full complement of staff would make it perfect here." The recruitment freeze had been lifted in part and the service was once again recruiting support workers. In the meantime, gaps in the rota were covered by regular agency staff. An agency worker told us, "I'm agency but I get treated with such respect… I would be so happy to work for them all the time but I start university soon. Even though I'm agency I've been here a lot."

The service was open to the concerns of staff, whether through whistleblowing, supervision and staff meetings, or staff surveys. The provider had a whistleblowing policy and procedures, which were publicised to staff. Staff told us they would not hesitate to raise concerns. Staff records reflected that some staff had raised issues about working with particular colleagues; these concerns had been addressed fairly and constructively. A staff survey at the end of 2017, during the recruitment freeze, had identified disaffection on the part of some staff in relation to feeling supported and working relationships with colleagues. The registered manager had acknowledged this at a team meeting and had offered to discuss the survey issues if anyone wished. However, no-one had approached them to do so.

The service had established links with the local community. People routinely used local facilities such as shops, clubs and leisure centres. The service hosted events for neighbours and people's family carers, such as coffee mornings, cream teas, a summer fete, and Christmas celebrations. It also hosted a national Care Home Open Day event.

The service worked in partnership with health and social care professionals and other organisations, to ensure people's care needs were met and that staff kept up with good practice in supporting people with a learning disability. A number of people used the service for occasional respite, and staff liaised with social workers and other professionals to arrange stays, including ascertaining whether there had been any changes in people's needs. The registered manager participated in a local registered managers' network, which held meetings, seminars and conferences about developments in good practice and legislation affecting care services. They encouraged the deputy managers to attend these events also. The registered manager was also part of the local learning disability provider forum. Some people used facilities provided by a local organisation run by and for people with a learning disability, such as participating in a buddy scheme and attending Big Night Out events.

The provider had quality assurance processes in place, which helped to maintain standards and drive improvement. These included audits within the service and monitoring by the provider, for example, through peer audits by the manager of another service. Audits resulted in timed action plans that were followed through. The registered manager told us they felt well supported by the provider to run a person-centred service, even in a time of financial constraint where there had been a recruitment freeze. The rating from the previous inspection was prominently displayed in the hallway. The registered manager had also managed a sister service in Bournemouth for much of the past year, and so had a team of deputy and assistant managers in place. Staff did not act up into a deputy or assistant manager role unless they had the appropriate training and the registered manager had checked their competency to do so.