Leonard Cheshire Disability

Wharfedale House - Care Home Physical Disabilities

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

Wharfedale House - Care Home Physical Disabilities 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 service is registered to provide care and support for up to 18 people with a physical disability. Nursing care is not provided. The home is situated close to local amenities in Wetherby and has good transport links. At the time of this inspection there were 18 people living at the home. Some people had additional needs, such as living with dementia.

This comprehensive inspection took place on 20 February 2018 and was unannounced. At the last inspection in August 2015 we rated the service as 'Good' overall. However, we found improvement was required for the service to be 'Effective'. This was because was staff were not adequately supported with supervision and appraisal.

You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Wharfedale House - Care Home Physical Disabilities on our website at www.cqc.org.uk

At this inspection we found improvements had been made to support for staff. However, we recommend the provider review the current supervision system to make sure it is effective.

There were systems in place to look at the quality of the service and these identified areas that needed improvement. provided, action was not always taken where shortfalls or risks were identified. We recommend the provider review governance systems to make sure identified areas for improvement are acted on.

Overall, the systems in place to make sure that people were supported to take medicines safely were effective. However, we recommend the provider reviews the procedure for managing the disposal of skin patches.

There was a registered manager in place. 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 manager had good oversight of the service and there was a clear ethos of care.

People told us they felt safe at the service. Staff were confident about how to protect people from harm and what they would do if they had any safeguarding concerns. Risks to people had been assessed and plans put in place to keep risks to a minimum. Improvements had been made to the environment to make it safe and this work was planned to continue.

There were a sufficient number of staff on duty to make sure people's needs were met. Recruitment procedures made sure that staff had the required skills and were of suitable character and background. Staff were supported by a comprehensive training programme and supervisions to help them carry out their roles effectively. Staff were led by an open and accessible management team.

The registered manager and staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). DoLS are put in place to protect people where their freedom of movement is restricted and they lack capacity to make their own decisions. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were provided with sufficient amounts of food and drink. Where people required support with eating or drinking, this was appropriately provided, taking into account people's likes and dislikes.

People told us that staff were caring and that their privacy and dignity were respected. Care plans showed that individual preferences were taken into account. Care plans were up to date and gave clear directions to staff about the support people required to have their needs met. People's needs were regularly reviewed and appropriate changes were made to the support people received. People were supported to maintain their health and had access to health services if needed.

People were encouraged to follow their interests and take part in a range of activities.

People had opportunities to make comments about the service and how it could be improved. A complaints procedure was in place and people told us they knew how to raise a concern if needed.

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.

Robust recruitment checks were carried out on new staff.

People received their medicines safely.

People told us they felt safe at the service.

Staff had a clear understanding of their safeguarding responsibilities.

There were systems in place to protect people from the risks associated with care and support.

Is the service effective?

Good

The service was effective.

Staff received the training and guidance they needed to carry out their roles effectively.

Care staff asked people for consent before providing care and support.

People received support from care staff to manage their health needs.

There was a choice of food and drink which people said they enjoyed.

Is the service caring?

Good

The service was caring.

People received good care and support from the service.

People were treated with dignity and respect whilst being supported with personal care.

Care staff promoted people's independence.

Is the service responsive?

Good

The service was responsive.

People received person centred care and support.

Care plans were up to date and described how people's individual needs were to be met.

People knew how to make a complaint.

People had opportunities to take part in a range of activities.

Is the service well-led?

Good

The service was well led.

Quality assurance systems identified areas that needed improvement. However, we recommend the provider review their systems for checking actions have been completed.

People and staff had opportunities to feedback their views about the service.

There provider had a clear ethos of care.

People made positive comments about the service they received.

Wharfedale House - Care Home Physical Disabilities

Detailed findings

Background to this inspection

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

This inspection took place on 20 February 2018 and was unannounced.

The inspection was carried out by one adult social care inspector, a specialist advisor (occupational therapist) and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection had experience of a physical disability.

Before the inspection we sought feedback about the service from Leeds City Council commissioning and safeguarding teams, and Healthwatch. We reviewed the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is legally required to send us as part of their registration with the CQC.

We used information the provider sent us in the Provider Information Return. 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.

During this inspection we looked around the premises and spent time with people in their rooms and communal areas. We looked at records which related to people's individual care. We looked at three people's care planning documentation and other records associated with running a care service. These included medicine records, recruitment records, the staff rota, notifications and records of meetings.

We spoke with thirteen people who received a service and one relative. We met with the registered manager and deputy manager. We also spoke with three members of care staff, a volunteer, the cook and the activity worker. We spoke with the director of quality for Leonard Cheshire Disability, after the inspection.

Good

Is the service safe?

Our findings

People and their relatives told us that they felt it was a safe service. Comments included, "I feel safe and confident because I know the staff are around if I have a problem". Another person told us they felt safe because, "I became too heavy for my (relative) to carry me, so I feel much safer here".

There were up to date safeguarding policies and procedures in place which detailed the action to be taken where abuse or harm was suspected. Staff had received training in keeping people safe, and they told us they were confident about identifying and responding to any concerns about people's safety or well-being.

Records showed that any incidents or accidents were recorded and appropriate action taken in response. This included looking at any lessons learnt. For example, reviewing training for night staff following a moving and handling incident. On another occasion, the registered manager had written to a person after a medicines error, detailing the actions taken to prevent a reoccurrence. Any serious incidents or concerns had been reported to other authorities, such as CQC or the local safeguarding team, as necessary.

The care planning process included the completion of risk assessments, which detailed the risks to each person and the action taken to reduce them. Risk assessments were completed for areas such as moving and handling, nutrition and hydration and skin integrity. The provider used recognised tools, such as the Waterlow risk assessment, which considers the risk of skin breakdown.

We looked at the arrangements for the management of medicines. Systems were in place to ensure that medicines had been ordered, received and stored appropriately. The majority of medicines were kept in locked cabinets in each person's bedroom.

We observed a member of staff administering medicines. They explained to people what medicine they were taking and why. People were given the support and time they needed and offered a drink of water. Staff checked that all medicines were taken before signing the Medication Administration Record (MAR). Some people took their medicine through a tube into the stomach. We observed the staff member carry out this procedure with care and attention.

There was information and guidance about the use of 'as required' medicines, such as when to use and the dosage. This supported staff in being consistent about administration. We observed the staff member ask a person if they needed any pain relief. They demonstrated a good awareness the person's changing needs and explained, "The painkiller is prescribed every day, but [Name] does not usually want it. I will go back to the doctor to change it to 'as required'".

Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse. We saw from the controlled drugs records that the stock balance records were correct.

We noted that one person required a medicine administered through a patch. This was changed each week.

The deputy manager told us it was usually placed on the same part of the body. There was no information to guide staff on the need to place it on a different part of the body to prevent skin problems. The deputy manager told us when the patch was changed it was put, "In the nearest bin". This was not a safe way to dispose of patches. We spoke with the registered manager about this, who acknowledged the issue and said they would ensure safe disposal in future.

We recommend the provider review medicines management to make sure care staff dispose of medicines safely and appropriately.

Regular checks were carried out on the environment and equipment to make sure it was safe. These included checks on lifts, hoists and wheelchairs. There were up to date test certificates in place for electrical wiring, gas safety and legionella. Environmental risk assessments covered areas within the building to maintain health and safety standards.

There were regular checks on the fire system to make sure it operated correctly. These included weekly fire point tests and monthly emergency lighting checks. Fire drills took place every three months. A fire risk assessment was in place which included evidence of actions being taken to make improvements.

There were personal emergency evacuation plans (PEEPs) in place for people. These made sure staff were aware of the level of support people required should the building need to be evacuated in an emergency.

We observed the environment, including bathrooms and toilets, to be clean and maintained to a safe standard. Cleaning staff were on duty and all staff were seen to use protective equipment, such as gloves and aprons, where appropriate. Staff had received training in infection control and there was a nominated 'infection control lead' who took responsibility for maintaining standards.

There was robust system in place to make sure new staff had the right qualities to support people with a physical disability. We reviewed staff recruitment files and saw that applicants had completed an application form which was discussed at interview. References were sought prior to employment and checks were carried out on each applicant's suitability for the position. A criminal background check was provided by the Disclosure and Barring Service (DBS). The DBS is a national agency that holds information about criminal records and those barred from working in care.

People who used the service attended interview panels so they could have a say in who was recruited. The deputy manager told us, "Residents will tell us if new staff do anything wrong. They let us know".

There were sufficient numbers of staff to meet people's needs and keep them safe. The deputy manager told us the use of agency staff had reduced and none were being used the week of our inspection. This meant that the staff team was consistent and recognisable to people who used the service. The manager used a dependency tool to check staffing levels to make sure there were sufficient numbers of staff to meet people's needs. People told us there were usually enough staff on duty but that occasionally there is a shortage of staff. Most people told us they did not have to wait long for care if they required assistance.

Some people commented that they had to wait for there to be sufficient staff on duty if they wanted to go somewhere, because they needed a staff member to go out with them. Sometimes this could be the next day. However, people said this was not a big inconvenience and staff would help when they could. People told us they usually advised staff of their plans in advance.

Good

Is the service effective?

Our findings

At our last inspection, carried out in June 2016, we found the service required improvement to be effective. We identified that staff did not receive adequate supervision and appraisal to support them in their roles. At this inspection we found some improvements had been made.

At this inspection we asked the registered manager about staff support. They told us that staff had four supervisions a year, one of which was a yearly appraisal. These supervisions included an observation session and group supervision. The registered manager said they often had informal chats with staff, either to check that they were okay or because the staff member wanted to talk about something.

Staff told us they received occasional supervision but one staff member could not remember when they last had one. One staff member's record showed they had an observation in January 2018 and one-to-one supervisions in March and October 2017. We spoke with the director of quality after the inspection, who told us observations should be followed up by a one-to-one supervision afterwards, to discuss any learning from the exercise and development needs. This had not been happening, and there had been no audit of supervision practice to check it had improved. The staff we spoke with spoke with told us they felt supported and there was good teamwork. One staff member said, "I've worked in care before, and this is good here, we're a team, not just individuals". However, we recommend the provider review the effectiveness of the current arrangements for supervision, to make sure staff get the support they need.

Staff told us they got the training they needed to maintain skills and their own professional development. Staff had received training in areas the provider considered essential, such as mobility, manual handling and communication. The registered manager kept a training matrix which gave an overview of training completed by staff. This meant they were able to monitor and arrange training as needed. A visiting professional commented on staff competence and said, "Here, I don't have to keep reminding staff. They have a good level of training in moving and handling and have a good range of equipment".

New staff were given a 12 week induction to support them in understanding their role and the routines at the service. This included shadowing other staff for two weeks and observing care practice. Induction included regular review of workload and progress with a senior member of staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

There was evidence in care plans that people's capacity was considered when decisions needed to be made. For those people that did not have the capacity to make a specific decision, mental capacity assessments and best interest decisions had been completed. A best interest decision is made on behalf of a person who lacks capacity, by representatives, such as relatives and professionals.

An Independent Mental Capacity Advocate (IMCA) was involved where required. An IMCA advocates on a person's behalf where they lack capacity and have no one to speak for them. However, one person's care plan stated, 'Do not ask [Name] to consent to anything. She has an IMCA'. This gave the impression the person was unable to consent to anything, even very simple decisions, which was not the case. There were also no contact details for the IMCA. We raised this with the manager who agreed it was misleading and said they would amend the information.

DoLS applications were submitted as required. Three people who used the service had a DoLS authorisation. The registered manager monitored the dates for when a DoLS needed review or reauthorisation so that this could be arranged in a timely manner.

The people we spoke with told us the food was good and there was plenty of choice. Comments included, "I've enjoyed the food here. It's flexible and plenty of choice", "Good food" and "I lived on microwave food in the community for seven years and now I eat home cooked food".

We observed a mealtime in one dining area. People were able to sit where they liked and tables were adjustable so that wheelchair users could eat their meal comfortably. One person chose to sit by themselves in a different part of the room and had a specially adapted table to allow them to do this. Staff offered support as required. One person needed full assistance with eating and a member of staff supported them sensitively and at an appropriate pace.

We spoke with the cook who confirmed food was freshly cooked and that people had choices. We looked at the menu plan for the next four weeks and saw there was a range of nutritious, well-balanced meals, which included alternatives. The cook maintained a list of each person's preferences, allergies and special requirements, for example, pureed or soft food.

Staff monitored food and fluid intake of those people at risk of malnutrition or dehydration. Assessments had been carried out using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults are malnourished or at risk of malnutrition. Systems were in place to ensure people who were identified as being at risk of poor nutrition were supported to maintain their nutritional needs.

All the care records we looked at contained a pre-admission assessment to consider people's needs before they moved into the home. This was to make sure the provider could be confident they were able meet people's needs and had the right facilities to ensure safety and comfort. The assessment of peoples' needs was wide-ranging and covered many aspects of their general welfare.

Records showed that people were referred to other health care professionals, such as a doctor, chiropodist or dentist, when needed. Prompt action was taken where a health need had been identified. Where there were concerns about people's weight, or problems with eating, a referral was made to a dietician or the Speech and Language Therapy team. Support with mobility was provided by an occupational therapist. A visiting professional told us, "Staff act in a timely way and make appropriate referrals when people's needs change".

Records showed people were able to access wider health screening programmes as part of their health management.

The environment had been designed to meet the needs of people who used the service. Suitable equipment was in place. Corridors and rooms were spacious and accessible for wheelchair users. The provider made changes to the environment to suit people's needs, if required. Two people told us how there accommodation had been adapted after they became married.

Good

Is the service caring?

Our findings

People we spoke with told us the service was caring. Comments included, "Lovely family atmosphere", "I love this home" and "I am very happy here". Relatives also described a caring service. One relative said, "I am very pleased with the home. My mum has dementia and she is well looked after".

People described a caring staff team. One person told us, "The staff are really kind and make sure I'm comfortable" and another said, "The staff are lovely".

We spent time in the communal areas of the home. There was a friendly, positive atmosphere throughout our visit. We saw that people's requests for assistance were answered promptly and politely. Throughout the visit, the interactions we observed between staff and people who used the service were kind, caring and person centred. Staff displayed open body language, good eye contact and got down to people's level to communicate with them. People appeared relaxed and comfortable in the company of the staff on duty.

All the staff members we spoke with thought that the people were happy and their needs were met. A volunteer at the service told us, 'I see a lot of what goes on. I'm a strong fan (of the service). I think there's a great atmosphere'. One staff member talked about how much they enjoyed their job and said, "I'm not here for Leonard Cheshire, I'm here for the people that live here".

The majority of the time we observed sociable chat and friendly relationships between people and staff. Staff clearly knew people well and showed genuine interest in people's lives. However, there were two occasions where we observed a staff member standing at a distance, away from people and observing, rather than interacting. We asked the registered manager about this who said they would expect all staff to be involved with people, and agreed to look into the matter further.

Staff were seen to treat people with respect and dignity. Care and support was led by the individual and people were involved in decisions about how and when support was provided. Any personal care was carried out behind closed doors to maintain people's privacy.

To promote a culture of respect, people who used the service had agreed a set of 'house rules'. These included, 'Speak to each other in a respectful way' and 'Not to shout or argue in communal areas'. The 'rules' were kept on display in the reception area. This demonstrated how people are supported to take responsibility for how they wanted to live.

People were encouraged to maintain independence and make decisions about day to day activities and routines. This was confirmed by the people we spoke with. Feedback included, "I get help when I need it here, but I am able to live more independently here than in the community" and "I choose what clothes to wear". People were seen to be able to go where they wanted in the service and make choices about what they wanted to do during the day.

There was information in people's care plans about communication needs and guidance for staff to be

aware of in relation to how they engaged with people. This supported staff to make sure people with communication needs were engaged in decision making.

People had access to advocacy support if needed. An advocate is someone who speaks on behalf of another person who is unable to speak up for themselves.

Good

Is the service responsive?

Our findings

The people we spoke with told us staff knew how to support them and understood their specific needs and preferences. One person said, "The staff look after me well".

People received person centred care which was responsive to their needs. Person centred care is about treating people as individuals and providing care and support which takes account of their likes, dislikes and preferences. We reviewed people's records and saw they were detailed and focussed on how people wanted their needs met.

Following an initial assessment, care plans were developed detailing the person's care needs in relation to areas such as moving and handling, health and personal care. The care files were comprehensive and well structured. Because of the amount of information, the more important documents were sometimes hard to find. We spoke with the registered manager about care plan layouts and the accessibility of information. Each person's care plan was kept in their room which meant they could look at it when they wanted. The registered manager acknowledged that their size meant they were not very portable and said they would explore this further.

Care plans were up to date and regularly reviewed, including where changes in needs had been identified. There was evidence in care records that people and their relatives were involved in the care planning process. People we spoke with told us they had seen care plans and were involved in care plan reviews. One staff member told us, "We sit with the residents and do their care plans with them. [Person's name] has just been sitting with [Staff name] to do this".

Care plans contained a social profile and life history document. This gave details about the person's preferences, interests, people who were significant to them, spirituality and previous lifestyle. This was useful information and supported staff to better respond to people's needs and enhance their enjoyment of life.

The service employed an activity co-ordinator who supported people in maintaining their interests, trips out and socialising. They had started an activity book for each person, which contained photos and comments about the activities they had participated in. This was a nice way to remind people about their involvement and provided a good talking point. The provider also made use of volunteers to support people to appointments or on outings.

The people we spoke with described active lives in the community. A member of staff told us many people went out on their own and made use of accessible transport. One person told us, "I play dominos with a friend. I catch the bus there. And also Harrogate and Leeds. The staff encourage me to live a full life and are very supportive". Another person said, "I am a 'greeter' at the local Catholic church on a Sunday and hand out the newsletter. This gives me contact with community life".

People were supported to go on holiday if they wanted. One person confirmed this and told us, "I've been on

holiday to Lincoln with another lady, in adapted accommodation. Two staff came to look after us".

A complaints procedure was in place which detailed how people could raise a concern. A copy of the procedure was kept with each person's care plan. People told us they were aware of how they could make a complaint.

The registered manager maintained a record of the complaints received, together with the action taken in response. There were clear details of each complaint, which included the desired outcome for the complainant. Investigations had been carried out as necessary and there was evidence of action being taken. For example, one complaint was about a lack of food for a diabetic diet. The record showed the registered manager had spoken with the chef and confirmed with the complainant that the matter had been resolved.

The service does not routinely support people at the end of their lives. However, the registered manager confirmed that if it was someone's choice to stay at the service then they would be supported to do so.

Good

Is the service well-led?

Our findings

There was a registered manager in place. They had good oversight of the service and knew people well.

We looked at the quality assurance systems in place. The registered manager carried out a number of audits to check procedures were being correctly followed. These included audits of call bell times, information governance and care plans. The majority of audits identified if there were any actions needed to make improvements and showed when these had been completed.

However, two separate audits in December 2017 had identified that a container of fluid thickener was kept in an unlocked kitchen cupboard and it needed to be removed. NHS England issued a Patient Safety Alert regarding the safe storage of food/fluid thickener in 2015, following the death of a person in a care home. We checked the cupboard and the thickener was still there. Although the container was effectively 'out of reach' of people, the audit process had not been effective in following through on actions. The deputy manager removed the container when we pointed this out.

We recommend the provider review governance systems to make sure identified areas for improvement are acted on.

The registered manager completed a service 'health check' every two months which gave an overview of all aspects of service provision. This included actions needed to make improvements and a review date. A senior manager also carried out a service audit each month which included getting feedback from people and staff as well as reviewing care practice.

We talked with the registered manager about their motivation and the culture of the service. They told us, "I like being in an organisation where I can provide the care people deserve. My values sit with those of Leonard Cheshire. Being positive and proactive".

They continued, "I believe everybody has equal rights. We treat everyone with respect. We have a mix of staff. I also expect residents to treat each other respectfully. The manager explained that to support this people who used the service has been involved in writing the house 'etiquette'. The registered manager explained this was promoted within the staff team through team meetings which were used to have discussions about person centred care, team work and values.

The registered manager talked about plans for future improvements. These included getting people more active by converting an unused bedroom to a gym as well as a 'green gym' in the garden. There were also plans for redecoration and refurbishment which would be agreed with the people who used the service.

People made positive comments about the service they received. These included, "I am very pleased with the home", "The manager is really good", "I have been in a number of homes and this is the best" and "[Manager name] has integrity and looks after the residents' concerns".

People who used the service and relatives were given opportunities to feed back their views and make suggestions about the service. There were resident meetings every month. The registered manager told us they currently chaired this meeting at the request of people. They added that they would like to withdraw from the role so that people took more control. The provider was undergoing a consultation with people who use their services with regard to a rebranding.

As well as team meetings, staff had opportunities to contribute their views and suggestions through the 'staff association'. This was a Leonard Cheshire forum where staff representatives could feedback to senior management.

We spoke with a representative of the provider after the inspection. The director of quality told us they were aware that the service needed some improvements. They told us the provider had a quality improvement plan to make sure services were person-centred and focussed on good outcomes for people. The provider was piloting new ways of working which included outcome based care and support, a review of documentation and the introduction of an active support model. Active support is about empowering people to participate fully in all aspects of their lives. The provider supported a Customer Action Network which was a representative group of people who used the service. They were involved in developing a 'customer charter', which would detail what people could expect from the provider.