Wolfeton Manor Healthcare Limited

Wolfeton Manor

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 unannounced inspection took place on 5 May 2016.

Wolfeton Manor provides residential care for up to 31 older people. There were 27 people living in the home at the time of our visit, some of whom were living with dementia.

There was a registered manager. 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.

People were not always protected from the risks of falling from a height likely to cause harm. Not all windows in the home were restricted to reduce the risks of people falling from height. Windows in three people's bedrooms on the first floor were unrestricted which meant they opened wide enough for a person to fall or climb out. The provider had completed a risk assessment which was repeated during our inspection. The risk assessment concluded the risk of a person coming to harm by falling out of an unrestricted window was "unlikely." However during our inspection we saw one bedroom was unoccupied and the window was open. This meant anyone in the home had access to the open window.

Some hot water taps did not have temperature regulators, which meant the hot water temperature was not always at a safe level for people. The Health and Safety Executive provides guidance on hot water temperatures in care homes and states hot water above 44 degrees can present a scalding risk to vulnerable people. The provider made checks on water temperatures and the hot water in one room was recorded at 70 degrees, other hot water temperatures were recorded over 44 degrees. We spoke with the regional manager and staff completed a risk assessment for unregulated hot water. The likelihood of people being scalded was assessed by staff as 'possible'. The provider identified what actions they would take to reduce the risk of people being scalded and indicated actions would be completed within seven days.

People were offered a choice of how they spent their day and had personalised care plans which were tailored to their individual needs. People were treated with kindness and respect and one person described to us how staff respected their privacy and dignity. There was a relaxed atmosphere within the home and people appeared comfortable in each other's company and with staff.

People had access to healthcare when they needed it and recommendations from healthcare professionals were carried out.

People were involved in decisions about their care; they were asked if they disliked anything about the home. We saw people's comments were acknowledged for example changes were made to one person's care plan after they had said they did not like eating in the dining room. There was a monthly meeting and people were invited to offer suggestions about the home, such as which activities to organise.

The provider was meeting the requirements of the Mental Capacity Act 2005. One person was subject to a Deprivation of Liberty Safeguard (DoLs), their care plan had been updated to reflect the conditions of the DoLs and staff had an understanding of their responsibilities relating to it. People told us staff respected their rights to make decisions for themselves.

Staff told us they had enough training and support to carry out their jobs. There were systems in place to provide staff with regular supervision and staff had an annual appraisal.

There were processes in place to ensure the quality of the service was regularly reviewed and improvements made. The registered manager had introduced a new system for recording people's care plans and daily records.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Three windows did not have window restrictors which meant there was a potential risk of a person falling from a height. Some hot water taps did not have water temperature regulators and hot water was above recommended temperatures.

There were enough staff to meet the needs of people living at the home.

Medicines were administered and stored correctly.

People had a full assessment which identified any specific risks. There was a care plan which provided guidance on how to minimise the risk.

People were at reduced risk from harm and abuse. Staff understood their responsibilities for identifying and reporting potential abuse.

Is the service effective?

Good

The service was effective People had sufficient food and drink. They were offered a choice at mealtimes.

Staff understood the requirements of the Mental Capacity Act 2005 (MCA) and how this applied to their daily work.

Staff had the necessary skills to meet people's needs.

People had access to healthcare when needed.

Is the service caring?

Good

The service was caring. People were cared for by staff who treated them kindly.

People had their privacy and dignity maintained.

People were involved in decisions about their care.

The home was accredited with Gold Service Framework at a

commend status for end of life care.

Is the service responsive?

Good

The service was responsive. People had individualised care plans which described the care and support each person needed. People had been involved about the way they wanted to be supported.

People were provided with a range of activities which included trips out.

People told us they knew how to raise concerns. There was a complaints policy and complaints were investigated by a member of the management team.

Is the service well-led?

Good

The service was well led. People and staff told us the registered manager was accessible and available.

There were systems in place to monitor the quality of the service and to ensure improvements were on-going.

Wolfeton Manor

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 5 May 2016; it was carried out by one inspector and one inspection manager and was unannounced.

Before the inspection, the provider completed a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. At the inspection we asked the provider to tell us anything they thought they did well and any improvements they planned to make.

We spoke with seven people and two relatives and one visitor. We also spoke with staff which included the registered manager and the regional manager, as well as the deputy manager the chef, maintenance staff and four care workers. We looked at five care records and five staff files. We also spoke with two healthcare professionals and contacted a representative from the local authority. We saw four weeks of the staffing rota, the staff training records and other information about the management of the service.

We used the Short Observational Framework for Inspection (SOFI).This is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from the risks of falling from a height likely to cause harm. Not all windows in the home were restricted to reduce the risks of people falling from height. Windows in three people's bedrooms on the first floor of the home were unrestricted and large enough to allow a person to fall out. The registered manager told us that this was people's personal choice for ventilation. The regional manager told us that the people using the rooms had capacity to make the decision regarding unrestricted windows and that two people had restricted mobility which lessened the risk. They also told us that no other person in the home was at risk from entering these rooms and falling from the windows.

One person's risk assessment detailed that it was the person's choice to have the window unrestricted and that the window should be closed when the room was unoccupied. We saw that this window was open and the room was unoccupied contrary to this risk assessment. The environmental risk assessment scored the standard associated with window restrictors as 'not met'. The registered manager told us that this environmental risk assessment was completed in July 2015. A further risk assessment was completed by staff during the inspection which assessed the risk of falling from these windows as 'not likely'. This assessment also stated that signs would be placed upon the windows to alert people to the risk of falling.

People were not always protected from the risks associated with hot water. Maintenance staff told us that all baths in the home had water temperature regulators to reduce the risk of people being scalded. However, a number of basins did not have temperature regulators and temperatures had been recorded above 44 degrees centigrade with one water outlet in a person's room being recorded at 70 degrees centigrade. The Health and Safety Executive guidance suggests hot water temperatures in care homes above 44 degrees can pose a scalding risk for vulnerable people. Maintenance staff told us that where water outlets in people's rooms were not temperature regulated staff used bowls to ensure that water was of a safe temperature. The regional manager asked maintenance staff to highlight all rooms where the water temperature was not regulated. A risk assessment for unregulated hot water was completed by staff during the inspection. The likelihood of people being scalded was assessed by staff as 'possible'. The risk assessment indicated that signs alerting people to the hot water would be placed in the relevant areas and the provider's facilities manager would address the issue within seven days.

People expressed confidence in living in the home and told us they felt safe and secure. One person told us "I wouldn't be here if it wasn't safe." A relative told us that while their relation was living in the home "We have no worries we know they are very safe." There were sufficient staff to meet people's needs. The registered manager told us they used a rating scale which calculated people's level of dependency. This helped them plan how many staff were required to be on each shift to meet people's needs Staff told us that when the shift was covered fully there were enough staff. However occasionally when staff were unavailable for work at short notice they felt under pressure. We spoke with the registered manager who told us the staff team were "fantastic" and rallied round to cover when there were gaps in the roster. They told us they had two part time vacancies for care assistants which they were recruiting to cover unplanned absences. The provider carried out checks before staff were employed to work in the home. Checks included references, identification and checks of criminal record and suitability to work with vulnerable people with the

Disclosure and Baring Service (DBS). Gaps in employment history were explored at interview and had been documented on the applicants staff file. Staff did not start work until satisfactory checks had been completed.

Medicines were stored securely and administered by designated staff, who had received appropriate training. A Monitored Dosage System (MDS) was used for the majority of medicines. Medicines were absent from the MDS which indicated that they had been given as prescribed. However, one person's MDS was out of sequence and contained eight day's supply of medicines rather than the expected seven. The registered manager investigated this and told us that the person had declined one dose of their medicine and this had not been correctly recorded on the Medicine Administration Record (MAR).

Medicines had been signed as given on the MAR and there were no gaps in recording. However, the name of one person documented on a MAR did not correspond with the name printed on the pharmacy label of the medicine. The registered manager told us that the person's preferred name had been recorded on the MAR and their given name printed on the pharmacy label of the medicine. The registered manager rectified this to ensure the same name was used on both the MAR and the pharmacy label.

Medicines requiring refrigeration were stored in a designated pharmacy refrigerator. This refrigerator was operating with a safe range and maximum and minimum temperatures were recorded daily. The registered manager made changes to the temperature recording chart during the inspection to provide greater clarity and assurance that the refrigerator was operating within a safe temperature range.

People were at reduced risk of harm and abuse. Staff had received training in safeguarding vulnerable adults and were able to describe to us how they would recognise abuse. Staff were aware of the correct processes to follow in order to report abuse, including how to report concerns about poor practice. Staff were aware of whistleblowing procedures, one member of staff told us they would escalate concerns to their line manager however if it concerned them "I would have no hesitation in going to the CQC or the safeguarding team or even the police." They reiterated that people's safety is paramount.

People had a full assessment of their needs which included specific risk assessments, such as pressure areas, eating and drinking and mobility. When a risk was identified there was a care plan which provided guidance to staff how to support the person in such a way as to reduce the risk. For example one person had a preference for being in the bath unaccompanied by staff. There was a risk identified associated with the level of support they required to get in and out the bath. The care plan took into account the persons preferences and how this could be incorporated into a safe plan which enabled them to have support to get in the bath then the opportunity to have time alone. The person had agreed to the plan including an agreed time that staff would check on the person and accessibility of a call alarm.

The home employed maintenance staff to ensure the safety and upkeep of the building. They were in the home Monday- Friday and were able to deal with general maintenance issues as they arose. The registered manager was also recruiting a gardener to take responsibility for the outside area. One relative told us they could talk with the maintenance person directly if they wanted adjustments in their relations room such as moving the television. There was a schedule which indicated when contractors conducted relevant checks or if these were carried out by the home, such as checks of the hoists which were conducted by an external contractor.

Good

Is the service effective?

Our findings

People had sufficient food and drink. People had nutritional assessments so that any concerns were identified and if needed a special diet was provided. Staff were able to tell us about people's dietary needs for example one person was on a low fat diet and staff understood what foods were excluded from the person's diet. The chef told us they talked to people to ask what they liked and to get feedback on the meals. One person told us they had a poor appetite and did not always want what was on the menu, they told us the chef talked with them and offered them alternatives.

People told us the food was very good one person commented "the food is excellent." People were offered choices at meal times and at breakfast people could have something cooked. There was also a "help yourself" table which meant people could get their breakfast when they wanted. Relatives told us they were invited to stay for meals and also that the food was "excellent." Feedback regarding lack of salt in cooking and difficulty getting low fat yoghurt had been received from people as part of a resident's survey, which we saw had been acted on. For example salt was available on tables and low fat yoghurts were available.

Staff told us about their training and development and gave examples of how this had increased their knowledge and confidence to carry out their jobs. For example two staff talked to us about first aid training they had attended the week before and how they felt they would be confident to support people in a first aid situation. Staff also told us they had received additional training in the care of people living with dementia and found this helpful. One person told us staff were "Very good, they've been well trained -they get it right for me." The registered manager told us they actively encouraged training, which was confirmed by staff, one told us they were being supported to do a level five health and social care diploma another told us they were doing their level three.

Staff received regular supervision and appraisals in line with the supervision and appraisal policy. One member of staff told us supervision was supportive and was an opportunity for them to say if there were any issues but also was a good learning opportunity. They said "I can ask questions about things I'm not sure about and my supervisor helps me understand."

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 by 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). One person in the home was subject to a DoLs and staff understood the implications of this. The person's care plan had been updated to reflect the conditions of the DoLs.

Staff understood the principles of the MCA and how it applied to their work. Staff were observed asking people's permission and offering them a choice. One member of staff explained that one person had fluctuating capacity however they were still able to make decisions about their daily care needs. They told us it was important to respect people's rights to make decisions. One person told us "If I don't want to get up –I stay there – staff ask me later."

There were systems in place to monitor people's health care needs. One relative told us that staff were attentive to their relations health and would contact a healthcare professional when needed, they told us "They are sensible and check it out first- they ring the doctor or nurse when it's needed." One healthcare professional told us staff liaised with them appropriately and followed recommendations they made. The provider requested feedback from healthcare professional as part of a quality survey and one professional commented, "We have a low rate of re-referrals from you which shows you put in place our recommendations." Input from health care professional was recorded in peoples care records which meant staff clearly understood what interventions or treatment were recommended.

Good

Is the service caring?

Our findings

People told us staff were kind and caring. One person told us "The staff are wonderful, we are treated with respect." Another person told us "They are very, very kind-all of them- you wouldn't get better at the Ritz." A relative told us "We get invited for lunch- we feel like one of the family."

People were clear why they had chosen to live in the home. One person told us they had "Done a lot of research." They explained it had been a hard decision for them selling their home and moving into a care home however they felt staff had supported them sensitively and in a way which they felt had made the move easier. Another person told us they had come for a short stay and had decided to stay "I've decided to stay longer, they are all so wonderful."

We saw staff sit with people and talk with them about things that appeared to interest them on a one to one as well as in communal areas talking with small groups. People addressed staff by their first names and were familiar with them. Staff were able to tell us about people's individual needs and preferences. They could tell us about how people liked to spend their day and their individual routines, such as one person liked a shower every morning and one person liked to spend time quietly in their room.

One relative told us that staff were respectful of people and allowed them to make their own decisions, such as where they sat at meal times. They told us staff were understanding and flexible if people changed their minds.

During the SOFI we saw staff checking on people, they were unhurried in their approach to supporting people. We saw staff sit with people while they were talking with them and use of gestures and other prompts to ensure they were understood. Staff worked well as a team; there was frequent communication between staff to ensure that peoples' needs were being met. Staff were discreet and respected people's confidentiality.

People told us their privacy and dignity was respected. One person told us that staff always knock on their door and wait for permission to enter. They told us staff ensured the door is closed and curtains drawn before supporting them with care.

The home was awarded accreditation with the Gold Standards Framework in Care Homes and achieved a commend status. This is a nationally recognised award which recognises the high quality of care provided for people at the end of their life. Healthcare professionals told us the end of care life was very good. A relative told us they couldn't have asked for more when their relation was receiving end of life care. They told us that three staff had attended the funeral which had not been local.

Good

Is the service responsive?

Our findings

The service was responsive. People had personalised care plans which took into account their likes, dislikes and preferences. One member of staff told us they know what people like by reading their care plans as well as by getting to know people and asking them what they like. They told us that they always ask people for their preference even though it is written down as people might like to change their mind, they told us "I don't want to assume- I always check." One relative told us staff "Treat people as individuals." They told us their relation had a preference for female staff which was respected by the home.

People were involved in a review of their care plan. The review covered all aspects of the person's health and well- being. For example mobility, personal care, nutrition, sleeping and communication. People were asked whether the service could be doing any better for them. One person had requested they were woken up in the mornings so their hot drink didn't go cold. They told us that staff were doing that. People were asked whether they disliked anything about living in the home, one person responded they disliked eating in the dining room , their care plan was updated to reflect their preference, we saw the person was eating their lunch in their room.

The registered manager told us they had introduced mobile devices to replace handwritten care plans. The system was being introduced gradually and there was a period of using both systems until staff were confident they could use the new approach. The registered manager told us the benefits of the mobile devices were that staff could update peoples care records as care was delivered and staff did not have to go back to the office and hand write notes. One member of staff told us once they had learnt how to use the new system it took up less time. The registered manager told us the system was accessible for people, it could also be accessed remotely by families with the person's consent. This meant the care plans and the delivery of care was transparent and easily available.

The registered manager held monthly meetings with people; they were an opportunity for people to make suggestions and for information to be shared. One person told us they attended the meetings and found them useful; they told us staff listened to people's views and "We get what we ask for." We saw trips which had been requested in the meetings had taken place or were being arranged.

People were provided with a choice of activities. There were dedicated activity staff who provided activities seven days a week such as a memory box, quizzes, board games, and trips out and arranged for entertainers to visit the home. One person told us "I really loved the couple of singers last week, it was such fun." Another person told us "I love the quizzes." Some people were having a discussion about the memory box and were laughing and joking about some of the items from their childhood.

The provider had a complaints policy which detailed how complaints would be dealt with and how these could be escalated within the organisation and outside the organisation including reference to funding authorities and the ombudsman. The provider displayed a complaints procedure which set out how people could make a complaint. In a survey carried out three months prior to the inspection people rated the response to complaints and concerns as either good or excellent. A friends and family survey noted

comments such as, "Every time I have raised an issue it has been dealt with swiftly and efficiently".
Complaints were recorded and included details as to whether the complaint was upheld and whether the complainant was satisfied with the outcome of the complaint investigation. Complaint letters and responses were kept on file. The registered manager told us that learning from complaints was shared with staff at team meetings and supervisions as appropriate.
The provider maintained a compliments file which contained a variety of letters and cards with positive comments. The registered manager told us that these were shared with individual staff if they were specifically the focus of the compliment and were displayed in the staff area before being filed.

Good

Is the service well-led?

Our findings

The service was well led. There was a clear management structure which included the registered manager and a deputy manager. They were supported by a regional manager who visited the home at least once a month. There was a team leader on each shift to coordinate the shift, administer medicines and supervise staff to ensure people received the care and support they needed. The registered manager told us they provided "hands on care" which meant they kept up to date with peoples care needs. The deputy manager confirmed they worked shifts as well which gave them face to face contact with people as well as an opportunity to work with staff and be a positive role model.

Staff were positive about the home and described the team as friendly and supportive. There was a relaxed atmosphere in the home and staff told us they were happy in their work and with how the home was run. Staff told us they considered management to be accessible and supportive.

People and their relatives told us management were approachable. One relative told us "I know I can speak with (name) at any time." Another relative told us they were kept informed and can voice their opinion to the registered manager

Both the registered manager and deputy manager told us if they needed advice regarding staff personnel issues they contacted an external agency for advice. Such as the correct procedures and risk assessment to follow for pregnant staff. This meant management understood their responsibilities for staff.

The provider had a schedule of audits which checked on practice in relation to a variety of topics such as safeguarding, staffing and cleanliness. Audits were organised to map against the five key questions asked by CQC at each comprehensive inspection and used a variety of methods to collect information including speaking with staff, people using the service and looking at documentation. Action plans were attached to audits when areas for development had been identified by the audit. For example, one audit had identified the need for a security risk assessment; we confirmed with the registered manager that this had been completed. Another audit indicated the need for the home's statement of purpose to be updated; the registered manager told us that this was in progress. Action plans did not always have clear timescales for actions with a number of actions being completed 'ASAP'. The registered manager told us that they would consider ensuring timescales were more specific on any future action plan.

Incidents and accidents were recorded and actions taken as a result were documented. For example, one person had a skin tear which was referred to the community nursing service. Another person had a fall and was attended to by a medic. An analysis of incident and accident trends was carried out monthly and resulted in changes to people's care to reduce the likelihood of further accident. For example, one person had fallen a number of times and a referral had been made for an occupational therapy assessment for their walking aid.

The registered manager told us they held staff meetings in order to share information and to listen to staff views. These were held in different formats, such as a team leaders meeting and kitchen staff meeting. We

saw staff had asked for specific items to be purchased in order to improve the quality of care people received, such as new sheets and towels. The registered manager told us they had a rolling purchase programme and new items were continually being obtained, they told us they welcomed staff suggestions. We were told new sheets had been purchased.

The registered manager had introduced a monthly managers briefing to ensure that all staff received the same information about developments in the home. One member of staff told us this was effective as they were not always able to attend staff meetings.