Wyndham House Care Limited

Wyndham House Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We inspected this service on 3 February 2015. The inspection was unannounced .

Wyndham House provides accommodation and support for up to 45 older people, many of whom live with dementia. There were 37 people living at the home at the time of our inspection.

There was a registered manager in post. 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 and associated Regulations about how the service is run.

At our last inspection in June 2014, we found breaches of the regulations and asked the provider to make improvements to how people were protected; how the service was monitored; how records were kept and how we were notified of significant events. These actions had been completed.

The atmosphere of the home was welcoming and friendly and there were sufficient numbers of suitable staff to meet people's needs and keep them safe. There had been improvements over the last year and visitors were pleased with the refurbishment and decoration of the premises which had made it lighter and brighter for people.

Summary of findings

Health and social care professionals were positive about the home and the care and support provided to people living there. Staff were good at keeping relatives informed of events that affected their family members: something which they greatly appreciated.

Staff had received appropriate training for their role and had also received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards so that people, who could not make decisions for themselves, were protected. Staff knew how to manage risks to promote people's safety and independence.

People's needs were assessed and support was planned and delivered in line with their individual needs. Their health was monitored and they were supported to see a wide range of health professionals if needed. Medicines were stored correctly and people received them as prescribed.

The manager had implemented a number of improvements since our previous inspection and all areas we had identified as non-compliant with the Regulations then, were now compliant. However improvements were still required in a number of areas, including in how people were supported to maintain their nutrition and the level of activities available to them . We also identified the need for improvement in how staff moved people, the information about how people's behaviour was managed and the management of people's complaints.

We found two breaches of the regulations and you can see what action we have told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People were kept safe by staff who recognised the signs of potential abuse and knew what to do when safeguarding concerns arose. Potential risks to people's health and well-being had been assessed and measures had been put in place by staff to reduce them and ensure people's safety.

Medicines were managed well and people received them as prescribed by their GP.

There was a sufficient number of staff to look after people and provide them with the care that they needed.

Good

Is the service effective?
The service was not consistently effective.

People's health was regularly monitored and they were supported to see a range of health care professionals to maintain their well-being. People's mental capacity was assessed and appropriate safeguards were put in place to protect people who could not make decisions for themselves.

However support for people who required assistance with eating was inconsistent, and people's food and fluid in-take was not monitored adequately.

Requires Improvement

Is the service caring?
The service was not consistently caring.

People's decisions were respected and staff were good at keeping relatives informed of what was happening with their family member. However people's dignity was not always upheld in the way they were assisted to dress or supported with personal care.

Requires Improvement

Is the service responsive?
The service was not consistently responsive.

People's needs were regularly assessed, recorded and reviewed. However staff did not always respond effectively to people's needs and their concerns and complaints were not always dealt with properly and effectively. Activities for people to enjoy were limited.

Requires Improvement

Is the service well-led?
The service was not consistently well-led.

Requires Improvement

Summary of findings

The manager was approachable, supportive and caring towards both people and staff at the home. Staff received training and supervision for their role and were able to make suggestions and raise their concerns. There were systems in place to monitor the quality of the service but people's views of the service had not been analysed thoroughly and used to improve it.

Wyndham House Care

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 was 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.

We inspected this service on 3 February 2015. The inspection was unannounced and undertaken by two inspectors and a specialist advisor in dementia care.

Before our inspection we looked at all the information we had available about the service. This included information from notifications received by us. A notification is information about important events, which the service is required to send to us by law. We used this information to plan what areas we were going to focus on during the inspection.

During our inspection we observed staff interacting with people who used the service. We spoke with the registered manager, five care staff, four people who used the service and a visiting relative. A social worker and a GP visited the service during our inspection and we also asked their views. We looked at four people's care records to see if their records were accurate and up to date. We reviewed two staff recruitment files and further records relating to the management of the service including quality audits.

Following our inspection we contacted a number of health and social care professionals who knew the service well including three GPs, two social workers and two nurses. We also spoke with a further five relatives by telephone.

Is the service safe?

Our findings

At our previous inspection in June 2014 we found that there was not a robust system in place to check that staff were administering and recording medication safely. All senior staff had received further training since our last inspection and observations of staff administering medication to people had been introduced. A formal audit of all the medication administration records (MAR) was now completed after each medicines round to ensure they had been completed correctly by staff. This had reduced the number of missed signatures significantly since being introduced. Protocols for people who only required their medicines infrequently had also been written to ensure people received them consistently and only when needed.

There was secure storage for medication and the temperature of the storage areas and fridges had been monitored daily to ensure they were at the correct level. There were no staff signature omissions on the MAR charts we reviewed, indicating that people had received their medication as prescribed. The date on which bottles of liquid medications had been opened had been recorded and stock control was good. We found that ointments and creams were stored securely in bathroom lockers in individual people's bedrooms. MAR charts were fixed to the inside of the person's wardrobe. These had been accurately and clearly completed by staff indicating that people had been given their topical medicines when needed.

Staff told us they received regular training in how to protect people and demonstrated a satisfactory awareness of safeguarding procedures and the correct action to be taken in response to incidents. Staff felt confident that they would be able to spot any signs of abuse and told us how they had been supporting one person who regularly hit out at other people. Training records we viewed showed that staff had received training in protecting people.

We found that any potential risks to people had been assessed by staff to ensure people were protected from harm. There were relevant risk assessments in people's files including for pressure care, bathing, infection control, manual handling and medication when off the premises with family members. There were also clear evacuation plans for use in the event of a fire so that people could exit safely.

We saw two staff members using a lift to pick someone off the floor when they had fallen which could have caused both the person and the staff injury. We spoke to the manager about this who told us she would take action to address this with the staff members concerned.

There were sufficient numbers of staff on duty to meet people needs. People reported that staff came when they called and they didn't feel rushed when getting ready or moving about the home. Relatives told us they had no concerns about the levels of staffing. Throughout our inspection, when people called for assistance staff attended promptly, for example when requesting assistance to go to the toilet. One person remained in their room throughout our visit and we noted that they were checked on regularly by staff. Staff stated that, although at certain times in the day it could be busy, there were enough of them to support people with their personal care and daily routines. They stated that no-one's needs had ever been neglected due to a shortage of staff. The manager stated she regularly reviewed people's dependency levels and could increase staffing levels if required. She told us an administrative assistant was about to be employed, freeing her up to undertake a range of management tasks in the home.

Staff reported that their recruitment had been thorough and that they had had to wait for their disclosure and barring service check to be returned before they could start working at the home. They told us that they had received a full induction to their job, which included shadowing an experienced member of staff before they were allowed to work on their own. We checked the personnel files for two recently recruited members of staff which contained the necessary evidence to show that they were suitable to work with vulnerable people. However the registered manager interviewed alone, and no record of the interview was kept to demonstrate it had been undertaken in line with good employment practices.

Is the service effective?

Our findings

Menu planning at lunch time was not person centred. People were served the same meal during lunch and were not always told what they had been given. We did not observe care staff giving choices about main meals or desserts. When people asked what was for lunch everyone was told, 'pork casserole'. No alternatives were offered or shown to people at the time the meal was served. There were no aids such as pictorial menus to help people make meaningful choices about what they ate. The meals were served fully plated up, thereby denying people choice in how much and what they ate.

We observed the lunchtime meal in two areas of the home. We found that people had to wait a considerable time for their food to be served which, for some, caused them agitation and distress. One person had their lunch placed on a side table which meant they struggled to feed themsleves due to its height and postion.

Support for people who required assistance to eat was inconsistent. There were instances of good practice when staff were encouraging, made conversation and assisted the person at their own pace. People were assisted to move into safe comfortable positions for eating and were offered aprons appropriately. However, we also observed people who were moved without their consent or being told what was happening, spoonfuls of food were presented while the person was still chewing and the person's face was wiped with the spoon rather than a tissue or napkin. One person who, when the dessert was brought, said they did not like it after the first mouthful was not offered any alternative.

A person who remained in their room had a fluid balance chart in place. The record showed that they were regularly offered drinks throughout the day. However the chart was not totalled at the end of the day, there was no record of the total that they should be aiming for and when they went down to the lounge the chart did not follow them so no entries were made. This meant their total fluid intake was not monitored to ensure they were getting enough to drink. We looked at food charts for two people which were not detailed enough to show what they had actually eaten.

There were no snacks or drinks available in the lounge, people waited for the tea trolley to arrive although two people repeatedly asked about breakfast and lunch. Staff did not attempt to ascertain what they were trying to communicate with their repetitive questions, for example, establishing whether they were hungry, thirsty, bored or simply needing company.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our previous inspection in June 2014 we found that staff did not receive regular supervision and appraisal of their performance. During this inspection in February 2015, staff told us they received supervision about every three months which they described as 'supportive' and which were used to discuss any of their work related problems or training needs. All staff had received an annual appraisal to ensure they received feedback about their performance and to identify their training needs.

Staff reported that they had the training needed to provide safe and effective care to people. They reported that the manager often suggested courses they might like to attend and felt they would be allowed to attend training they had identified for themselves. Ten staff were about to undertake a long distance training course in dementia care to increase their knowledge and skills in this area. A high proportion of staff (22 in total) had gained an NVQ level two or above in care- (a nationally recognised qualification for the care sector).

At our previous inspection in June 2014 we found that people's mental capacity was not being assessed and that best interest meetings were not held when needed. All staff had received training in September 2014 and showed an improved awareness of the legal requirements for people who could not make decisions for themselves. Staff now undertook assessments of people's ability to make decisions for themselves on a range of day to day issues, evidence of which we read in people's care plans. We saw that an appropriate Deprivation of Liberty Safeguarding (DoLS) referral had been made for one person as staff were restricting their liberty.

We spoke with four GPs all of whom knew the home well. All told us they received appropriate referrals, that staff were competent and that prescribed treatment plans were followed by them.

The registered manager informed us that the service liaised with five doctors' surgeries and that a district nurse visited at least twice a week. Members of staff accompanied people to hospital unless a relative was able to do this.

Is the service effective?

People were taken to a dentist, and the registered manager was investigating obtaining the service of a dentist who would visit the home. There was good liaison with outside agencies including chiropody, district nursing and occupational therapy. An audiologist visited the home every three months to check people's hearing aids. We noted in one person's notes that they had seen a range of health care professionals in the previous two months to our visit to maintain their health and well-being.

Staff did not always respond effectively to people's mental health needs. One person, who was particularly anxious, asked staff to come and sit with her. The staff member responded quickly and was able to reassure and distract the person. However when this person once again became very anxious at lunch time staff did not reassure her. As a result, their behaviour escalated over a period of half an hour to the point where they were continuously shouting and calling out. When we asked about their care plan to manage their distress the staff member could not describe what specific strategies were in place. Staff were quick to spot people's tearfulness and distress but were not always sure how to respond beyond trite remarks.

Is the service caring?

Our findings

People were smartly dressed wearing matching outfits with accessories. However more dependent people were less well kempt. We noted several female residents with facial hair, which was undignified for them. There was no information their care plans about how their facial hair was to be dealt with by staff. We noted that seven people had not been fully dressed. When we asked staff about this they could not provide a clear reason for why these people had been dressed without socks to maintain their dignity and keep their feet warm. We observed some staff talking over people's heads and pointing at people when allocating care tasks, "What will we do with him"; "We'll get him up next." This did not demonstrate valuing people or person centred care.

People we spoke with described staff as "nice", "caring" and "friendly". One person told us he was, "nicely looked after". Visitors told us that staff were kind and respectful and knew people's needs well. A GP who knew the home well told us, "Staff are never surly, they're cheerful and on the ball". People who visited the home spoke of its warm and friendly atmosphere, and the fact they were always made to feel welcome by staff.

Relatives told us that staff were very good at keeping them informed of what was happening with their family member. One commented, "They always let me know about important things". They also stated that they felt involved in their family member's care and one relative reported that she had been consulted about a recent change in her mother's GP practice. The registered manager showed us a storage room that was to be converted to a relatives' bedroom so that people's family members could stay overnight if needed.

One relative told us that their family member liked to dress in a specific way at times; this was respected by staff who recognised it could be distressing if they tried to encourage the person to change clothing.

Staff encouraged people to remain involved with the person's care. For example one gentleman regularly visited their friend and when staff saw him they fetched tea and snacks as this was an activity they enjoyed together. The visitor felt comfortable in the home and said they were pleased their friend lived there. They explained how the staff had helped them to develop positive ways to communicate with their friend and they felt more relaxed when they visited as a result.

Staff demonstrated caring relationships with people in their conversations and interactions. They used verbal communication which was adapted to the level of understanding of the person. Staff complimented people on their dress and appearance and engaged them in social and incidental conversation. However we also observed a staff member who approached people from behind and began moving them without explaining what was happening or why.

When staff supported people with personal care they were respectful and encouraging. We observed staff explaining what was happening to one person. They took account of their hearing and sight impairments and made effective use of touch to guide and support them. When assisting with personal care staff waited outside the bathroom ensuring the door was closed to maintain the person's privacy and dignity.

Staff were able to describe how to promote people's privacy and confidentiality by not sharing information outside the home or discussing people's needs in the hearing of other families or residents. Staff effectively promoted dignity by encouraging people to do as much as possible for themselves. For example, one person was encouraged to hold their own drink, they were provided with an adapted beaker and because of a sight impairment a staff member stayed and gave verbal prompts, this enabled the resident to maintain their independence.

There was good evidence of how the home advocated for people when working with outside health and social agencies. All requests for consultations or reviews were logged and their outcomes noted. Where a family had complained about a delay in treatment for their relative, staff were able to clearly show how they had sought professional help and the steps they had taken to attempt to resolve this matter. There was a record where the staff had made a complaint on behalf of one person about their discharge from hospital. The person had gained an apology and assurance that the hospital's practice would be reviewed in light of their complaint

Is the service responsive?

Our findings

One relative told us that their relative used to be a head of a school so the manager often let them sit in her office and 'help' with the paperwork, which their family member clearly enjoyed. Another person used to be a care inspector so staff gave them a clip board so they could inspect the home. Despite this, there were limited activities for people to enjoy. A vicar visited every third Sunday and there were monthly music and movement sessions, and a monthly visiting singer. However there were no daily activities scheduled for people and staff described the frequency of activities for people as, "hit and miss". When we asked people how they spent their time people were not clear about what activities might be available, one person said, "I just wander around." However a number said they enjoyed the visits from the hairdresser.

During our inspection there was a lack of stimulating activity for people and some people displayed distressed behaviour. The television remained on throughout the morning although no-one was watching it and most of the seating in the lounge did not allow people to have a view of the screen. The volume of the television impeded communication with people as both staff and the people they were talking to were shouting over the programme.

There were magazines and dominoes available in the lounge although these were not proactively offered to people. There were no trips or outings to places of interest for people to enjoy. One relative told us his mother had never had a trip out, and had not even been taken out to the home's gardens to enjoy fresh air and sunshine. Two members of staff told us they wished there were more opportunities for activity for people. In the most recent staff survey five staff commented on the need for more activities for people.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We reviewed the care plans for four people and found they contained sections about people's health needs, personal care and mobility amongst other things**.** Although, people did not feel involved in their care planning they did think that staff listened to their preferences.

Care plans described the care people needed and made good use of nationally recognised risk assessments for people's risk of malnutrition, pressure ulcers and dependency rating scales. Staff had used behavioural monitoring charts to log incidents of distressed behaviour for one person and these have been used to prompt a referral to mental health services. However, information in some people's care plans about their behaviour which challenged others was limited, and did not give staff enough information about how to best to promote people's well-being. The plans were not in a suitable format for people to understand and were kept locked away in a cupboard making them difficult for people to access.

The plans had been reviewed monthly to ensure the information about people's needs was kept up to date and accurate. Care records were enhanced by the use a book which documented people's needs, preferences likes and interest. However, it was not consistently clear that this information about people's specific likes and dislikes had been used to inform individualised care plans to ensure people received their in a way that they liked. We read the plan for one person whose first language was not English. We found that there had been little attempt to provide material or information in the person's native language, or the use of communication aids so that staff could better understand them, despite the person's care plan stating that they became distressed when they could not understand staff.

There was a complaints book in the main entrance to the home where people and their visitors could record any concerns they had . The visitors we spoke with had not had cause to make a complaint or express their concerns. They described the staff as always helpful when they visited and said if they were worried about a family member they would feel confident to approach any member of the team. One relative told us he had complained about his mother's dirty fingernails and was pleased that staff had responded immediately, cleaning and painting them that afternoon. Staff we spoke with were clear they would pass people's complaints and concerns to the manager or deputy manager.

Is the service well-led?

Our findings

Two GPs told us there had been great improvements in the home in the last few years and they had confidence in the leadership there.

The registered manager had a level 5 qualification in health and social care, and previous experience of managing care homes. She told us that their vision for the service was for it to develop as a specialist home catering for people living with dementia. The provider had employed a dementia care consultant who had visited the home three times in order to improve its services. However, there was no written vision and staff had limited knowledge about current dementia care practices. Staff told us they were aware of the increase in the number of people who were living with dementia at the home but did not have a clear concept of the vision for the future development of the service. We saw the minutes of staff meetings. These were handwritten and hard to read and staff who only work part time seemed unaware of these minutes even though the registered manager stated that they were displayed on the staff notice board.This indicated that information about service development and future plans was not effectively communicated to staff.

Staff knew about the home's whistle blowing policy and told us they would be confident to use it if necessary. Information about whistle blowing was on the noticeboard and was explained to all new staff as part of their induction to their job.

Staff felt that any suggestions that they made regarding improvements to the service were welcomed and acted on where appropriate. The registered manager gave us an example of a suggestion from a member of staff for provision of cupboards in the wet rooms for people's shoes and other belongings to be placed in while they were having showers. We saw that surveys had been carried out to obtain the views of people who used the service, their families and the staff. However, the registered manager told us that there had been no analysis of the results, other than looking through the forms to see if there were any main concerns. The registered manager said that a consultant would be guiding the service in analysing and responding to the survey results. Lack of analysis and action in response to all the feedback received from various sources represented lost opportunities to improve the service.

Staff said that their morale was good and they demonstrated that they understood their roles and responsibilities. They told us that the registered manager had an open door policy and was approachable, supportive and caring towards them as well as to the people who used the service. One staff member commented, "You can go to (the manager) anytime if there are problems". Another had commented in the most recent staff survey that, "Staff morale has improved immensely due to having good management which you can trust to do as they promise, as they are professional and committed to the home." Staff reported they would not hesitate to bring any concerns to the attention of management. They were confident that issues would be promptly and appropriately addressed but knew that, if necessary, there was a whistle-blowing procedure in place. The registered manager confirmed that this procedure was explained to new staff as part of their induction. This demonstrated that the service had an open and supportive culture.

Staff told us that they found supervision and appraisal sessions helpful and supportive. We were given examples by staff and by the registered manager of where issues such as confidence-building had been discussed. We were told by staff that they received clear feedback about their performance, for example through discussions with the registered manager about the self-assessments that each member of staff completed.

Our observations and comments from staff indicated that the registered manager promoted a caring environment. The registered manager was clear about her responsibilities, for example ensuring that the Care Quality Commission was appropriately notified of any relevant issues. The registered manager confirmed that the directors were supportive of the service and that there was a regular monthly visit to discuss issues and provide support, for example in the development of improvement action plans. Any requests, such as for equipment, were promptly granted.

At the time of our inspection, the registered manager was trying to establish better links with the local community through events such as a summer fete and visits by local carol singers. But community engagement remained limited and a visiting professional told us that the only opportunity people seemed to have to get out into the community was if family members took them.

Is the service well-led?

We saw that the service used quality assurance documentation produced for all the provider's homes. This consisted of quality audits with a series of 'key questions' in four main areas: environment; quality of staff; quality of care, and quality of management and organisation. Action points were noted and review of the resulting action plans was built into the process. This helped ensure that standards of service provision were maintained and improved. However they had been ineffective in identifying some of the shortfalls we noted during out inspection.

People's comments, concerns and complaints were not routinely logged. The records of a recent significant complaint about standards of care did not show how the issues had been resolved, what action was taken or what learning had occurred as a result of it. The manager has recorded a meeting with the family who complained as having an 'amicable outcome'. However, minutes of this meeting had not been kept. The paperwork in relation to this complaint was not dated or held in chronological order, making it difficult to establish if the manager's response had been timely.

We saw that a survey had been sent to other health and social care professionals in 2014. This had secured five responses, all of which were positive. One respondent noted that they were welcomed, "Promptly and warmly".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The registered person did not ensure that service users were protected from the risk of inadequate nutrition and hydration.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The registered person did not make suitable arrangements to provide appropriate opportunities for activity and for people to be involved in their community.**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.