Warrington Homes Limited(The)

Warrington Lodge

Inspection report

The Linleys
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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?	Requires improvement
Is the service well-led?	Good

Overall summary

This inspection took place on the 9 and 10 of February and the inspection was unannounced.

Warrington Lodge provides accommodation and personal care for up to 21 people with a diagnosis of dementia.

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 2008 and associated Regulations about how the service is run which corresponds to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.'

We saw staff offer people choices around activities, menu choices and gained consent before offering support. Members of staff showed a good understanding of the Mental Capacity Act 2005 (MCA). They were clear on how

Summary of findings

to follow the MCA principles to gain consent. The MCA assessments did not include the decisions people were able to make and the support they needed to make these decisions.

People told us the staff knew how they liked their needs to be met. Staff told us a person centred approach to meet people's needs was used. They said people were cared for as individuals and not as a group. Care plans were not person centred as they did not say how the person liked their care to be provided. The care plans were not detailed and did not give staff sufficient guidance to consistently meet the person's needs. We recommend that the service seek advice and guidance from a reputable source, about the management of behaviours staff find difficult to manage.

There was a programme of in-house activities and entertainment and during the inspection visit we saw some people were having pampering sessions from the staff.

People told us they felt safe living at the home. Members of staff had attended safeguarding adults training and knew the signs of abuse and the actions they needed to take if they suspected abuse was taking place. Staffing levels were adequate which meant there were sufficient numbers of staff to meet people's needs. We saw there were safe systems of medicine management.

People said the staff had the skills needed to meet their needs. New staff had an induction to prepare them for the role they were to perform. Essential training was provided and staff were encouraged to develop their professional qualifications. Support to the staff was provided through individual one to one meetings with a designated member of staff.

The staff we observed used a kind and sensitive manner towards people. People told us the staff were caring and their dignity and privacy was protected. Members of staff gave us examples to describe how people's privacy and dignity was respected. The "dignity tree" kept in the reception area had the staff posts of their definition of dignity.

People's views on the quality of the service were sought and overall they were happy with the standards of care and their feedback on improvements were considered. House Committee and Board of Governors assessed the quality of the service and devised future plans to maintain the quality of care and treatment provided to people. Audits were used to ensure standards were maintained and where they were not fully met action was taken to meet them.

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

Good

People told us they felt safe at the home. We saw safeguarding procedures were on display telling people and their relatives the actions they needed to take if they suspected abuse. Members of staff knew the signs of abuse and their responsibilities towards safeguarding people from abuse.

Staffing levels were adequate to meet people's needs and recruitment procedures ensured the staff were suitable to work with vulnerable adults.

We found safe handling of medicine systems were in place.

Is the service effective?
The service was effective.

Good

People said the staff were skilled to meet their needs.

New staff received an induction to prepare them for the role they were to perform. Essential training was provided and included dementia awareness and moving and handling. Staff were encouraged to improve their professional development for example, completing vocational qualification training. One to one meetings with a designated member of staff were for support and took place regularly.

We observed people were offered choices around activities and meals. Members of staff showed a good understanding of the principles of the Mental Capacity Act (MCA) 2005 and how consent was to be gained. However, MCA assessments were not properly completed. This meant the staff may not be fully informed of the decisions people were able to make and the support they needed to make them.

People told us the meals served were good. Staff told us they catered for people's preferred and special diets.

Is the service caring?
The service was caring.

Good

People said the staff were caring and their rights were respected. We observed the staff 's interaction with people was kind, patient and sensitive. Relatives told us they were kept informed of important events such as GP's visits and medicine changes.

People told us the staff protected their privacy and dignity. Members of staff gave us examples on how they respected people's rights.

Is the service responsive?
The service was not responsive.

Requires improvement

Summary of findings

Care plans were not person centred. They did not tell staff how people wanted their care needs to be met or have sufficient detail for staff to consistently deliver care and treatment. Members of staff said there were structures in place to ensure the care and treatment they provided was individual to the person. People told us the staff knew how they liked their care to be provided.

People's dependency was assessed and risk assessments were devised to lower the level of risk. For example, people at risk of malnutrition or who required support with moving and handling. We observed staff were using safe methods of moving and handling. Intervention records were maintained to monitor people assessed at risk of malnutrition.

We saw on display the programme of in-house activities and entertainment. On the day of our inspection we saw for some people in-house activities were taking place.

People told us who they would approach with complaints. The procedure on display told people and their relatives how to make complaints. Members of staff told us complaints received were passed to the head of care or manager for investigation

Is the service well-led?

Good

The service was well led.

The views of people were sought using surveys and the analysis showed they were happy with the service they received. Where additional comments to improve the service were made they were being considered.

Staff were clear on the values of the service. They said treating people with respect and dignity and promoting independence were values of the service.

Audits were used to assess the quality of care and where standards were not met action was taken to meet them.

The House Committee and the Board of Governors checked on the quality of service and developed plans to maintain the quality of care provided to people.

Warrington Lodge

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 9 and 10 February and was unannounced.

The inspection was carried out by an inspector and by an expert by experience who has knowledge in dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the home. During the inspection visit we spoke with people, their relatives and friends or other visitors, we interviewed staff and we used Short Observational Framework for Inspection (SOFI) to assess the way staff interacted with people. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with district nurses and external trainers. The records we reviewed included people's care records, medicine management system, policies and procedures and staff files.

Good

Is the service safe?

Our findings

People said they felt safe living at the home. One person told us "I feel safe we always have the same people [staff]." Another person said "They make sure I am safe. They explain why they want to support you." The safeguarding procedure on display was in a flowchart format which told the staff the actions to be taken for suspected abuse. Within the procedure were the contact details of the statutory body to be contacted where abuse was suspected. Members of staff told us they had attended safeguarding adults training. They told us their duty was to protect people from abuse and to report poor practice if suspected or they witnessed it from other staff.

Staff told us risks to people's health and welfare were assessed and action plans were devised to lower the level of risk. We saw people's dependency levels were assessed . We saw risks assessments for people at risk of malnutrition, for mobility needs and for developing pressure ulcers which staff reviewed to ensure the actions in place lowered the level of risk.

The potential of fire in the premises was assessed and an action plan devised. The fire risk assessment was reviewed annually to ensure the action plan was appropriate. the plan included personal evacuation profiles. The profiles assessed the support needed by the person from the staff to evacuate the property in the event of an emergency. The registered manager told us there were contingency plans in place to ensure people were accommodated and safe in the event of an emergency in the premises.

Accidents and incidents forms were completed following accidents. Staff said at staff meetings they were informed about incidents and accidents and changes in the care plan. The completed accident forms we looked at included the actions needed to reduce any further reoccurrence.

We observed there was enough staff on duty to meet the needs of people. Staff told us there was enough staff on duty. One member of staff said "There are four to five staff on a shift as well as seniors. The duty rota says who the senior is on duty." Relative's made positive comments on the consistent staffing levels. They had observed sufficient staff on duty to respond to people who needed support. The rota in place confirmed the comments by the relative and staff.

Recruitment procedures were robust and ensured the staff employed were suitable to work with vulnerable adults. Staff seeking employment had to provide in the application form details of their past employment and training and attend an interview. Checks were then carried out by the registered manager to ensure the candidates suitability to work with vulnerable adults.

Medicines were administered by staff who attended training to ensure they were competent to administer medicines. We saw there were individual medicine profiles which included the person's picture to enable the staff to identify the person. Also included in the profiles was essential information such as the best method of administering the medicine. Staff signed the medicine administration records (MAR) when they administered medicines. Where medicines were not administered codes were used to define the reason for not administering the medicine. A record of medicines no longer required by the person were maintained and signed by the person collecting the medicines for disposal.

A procedure and individual care plans were in place for administering as required medicines such as Paracetamol.

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Good

Is the service effective?

Our findings

People we spoke with and visitors said the staff were trained to be able to meet people's needs.

A member of staff told us the induction for new staff was good. A mentor (more experienced staff) was assigned to support new staff . Another member of staff said their knowledge on specific topics was tested to ensure they had a good understanding. A third member of staff said their mentor monitored their work to ensure they were competent to work unsupervised.

Staff attended essential and vocational qualifications to improve their skills and their professional development. Staff told us they had annual refresher training to ensure they followed good practice,, for example medicine training. An external assessor who supported staff to gain professional qualifications told us most staff were registered onto the diploma course and had completed or were working towards completing the full programme.

Staff told us they had one to one meetings. We were told at one to one meetings training needs and concerns were discussed. The trainer had designated responsibility for one to one meetings with staff and told us their role was supportive and included discussions with individual staff on their professional development and their performance. We were told staff were encouraged to undertake vocational training, the essential training staff had to attended and how this training was delivered. For example dementia awareness training was in-house through a training package.

Staff told us they had attended Mental Capacity Act (MCA) 2005 (assessment of people's capacity to make decisions and how staff support people to make these decisions) training. Staff showed they had a good understanding of the MCA and how to gain people's consent. One member of staff said "we assume people have capacity to make decisions. The social worker visits to assess people for more complex decisions." Another member of staff said "people have the right to make decisions, they are given choices and people are encouraged but not forced." They said people made decisions about their meals, clothes and activities and they described the methods used to help people make decisions for example, showing people the choices. We observed people being offered choices around activities as well as menu decisions. We saw staff gained people's consent before helping them with their mobility. Staff told us information about people's capacity to make decisions was kept in their care plans. The MCA assessments covered two stages and aimed to assess the person's ability and their level of capacity to make decisions. We saw at stage one people's level of capacity was assessed but the support needed by the person to make decisions was not included in the assessment. We saw that at stage two the decisions people were able to make with support was not listed. This meant the staff were not fully informed of the decisions people were able to make and the support they needed to make these decisions.

Deprivation of safeguards (DoLS) applications were made to the supervisory body for people who required continuous supervision and lacked the option to leave the home without staff supervision.

DolS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

People told us the meals were good, there was always plenty to eat and drink and they had choice of meals. One person said "I love the food it's my favourite."

The chef told us special diets and people's preferred meals were catered for. We were told people were asked about their likes and dislikes and a questionnaire ensured people were served with their preferred choice of meals. It was explained that for people at risk of choking soft diets were served and enriched diets with snacks between meals for people at risk of malnutrition. We were also told summer vegetables were grown in the premises.

The catering area had been inspected by food safety officers and a rating of five given. This was the highest rating that could be given.

We observed the support provided by staff to people who needed help to eat their meals. Staff offered choices of refreshments and meals, we saw staff ensured people had finished their meals before they removed the meal. We saw staff guide people to eat their meals with minimal support. We heard a member of staff say "let me show you, we can do it together" and then encouraged the person by saying "well done."

Good

Is the service effective?

We observed the building was well designed to meet the needs of people with mobility issues. Corridors were straight and wide to aid visibility and accessibility. We saw colourful pictures and props to help people living with dementia. For example pictures of fruit and vegetables were hung in the dining room which helped people living with dementia to identify their location.

Staff told us people were registered with a GP and visits were arranged by the care managers or senior staff for people who needed medical attention. Records of visits from health and social care professionals and recorded were the outcome of the visit.

Good

Is the service caring?

Our findings

People told us they were well cared for and their comments included “They are excellent, if I need help, someone will come and the staff here are all very good, I am well looked after.” A relative said “I think they’re very kind and caring, they always do their best and my father gets the best.”

Relatives told us they were kept informed about important events such as GP’s visits and medicine changes.

We observed staff interaction with people was kind, patient and sensitive. We saw staff speak kindly and sensitively with the person they were supporting. We saw when staff arrived on duty they asked people about their day and showed an interest in what people were saying.

People said the staff were polite, respectful and protected their privacy. One person said, “they always knock on doors and ask if they can go in. The staff are all very friendly and courteous. They are always good and ask consent.” Staff gave us examples on how to respect people’s rights.

We saw a “dignity tree” in the reception area where staff had posted on the tree their understanding of dignity. For example, 'treat people as you would like to be treated'. This "dignity tree" made people and visitors to the home aware of the staff’s definitions of dignity and also reminded the staff of their commitment to deliver care and treatment in this manner. The registered manager told us the staff had recently attended training on dignity and this tree had resulted from this training.

Requires improvement

Is the service responsive?

Our findings

Staff told us senior staff devised the care plans which they read. The care records we looked at had 'this is me' booklets which gave staff information on how people wanted their care to be delivered. Pre-admission assessments centred on people's daily living and how they wanted this care to be delivered. However, care plans lacked detail and were based on the task. For example, it was stated in a care plan that body language was used to communicate but how staff were to interpret the body language was not included. The information gathered on people's likes, dislikes and preferred routines was not used to develop care plans on how people liked their care needs met.

Some people at times refused personal care or used aggression to express their views. Members of staff told how they helped people to accept personal care for example, having background music or giving time. One member of staff told us how they diffused aggressive situations. Care plans did not guide staff on how to manage situations for people who refused personal care or for people who at times expressed themselves using aggression. This meant staff may not be using a consistent approach to manage difficult behaviours. We recommend that the service seek advice and guidance from a reputable source, about the management of behaviours staff find difficult to manage.

Staff told us the care and treatment delivered was individual to that person. One member of staff said "people are individual; they don't like the same thing." They explained the structures in place to ensure people's care was delivered in their preferred manner. We were told information was gathered from the person and their relatives and 'this is me' booklets introduced staff to people's likes, dislikes and preferred routines. Also the keyworker system (staff assigned to specific people) provided "personal touches" and keyworkers helped the person maintain a tidy room. Relatives said they were invited to care plan review meetings. We were told their suggestions about the delivery of care to their family member were requested and taken on board.

People were assessed for the potential of developing pressure damage, malnutrition and for people at risk of falls or with mobility needs. Where appropriate risk assessment were devised to lower the level of risk to the person. For example moving and handling risk assessments in place described the techniques to be used, the number of staff needed and the equipment needed. Intervention records such as food and fluid charts were completed by the staff for people at risk of malnutrition.

People told us the staff knew how they liked to have their care and treatment delivered. One person said the staff always explained "why they want to support you." A relative told us "staff are approachable and caring. I can see how they work. People get individually treated not in a group, their personality is recognised." Another relative told us the staff supported their family member to maintain contact with them. The staff we observed during the inspection visit addressed people by their preferred name and before people were assisted they were asked if they needed help.

We saw on display the range of in-house activities and entertainment to be provided. For example quizzes, pampering, ladies and gent clubs and dance and movement. One relative told us "there used to be more activities now XX watches television, more stimulation is needed. " Staff told us there was an expectation they provide in-house activities such as pampering sessions. On the day of the inspection we saw staff were providing pampering sessions to some people. However, the other people were watching television. The manager told us the recently recruited activities coordinator was taking steps to reorganise the activities programme. We were not able to discuss the activities programme with the activities coordinator because they were not on duty on the days of the inspections.

People told us if they had a complaint about their care the manager or owner would be approached. A relative told us the head of care would be approached with concerns. We saw the complaints procedure was on display which told people and their visitors how to complain and the actions to be taken if their complaint was not resolved. Staff told us complaints received were passed to seniors or manager for investigation. Complaints received were resolved.

Good

Is the service well-led?

Our findings

People's views were sought using surveys and the analysis showed 88% of the feedback was excellent to good. Comments to improve the service for people were made and were based on the environment and activities. The manager said the suggestions made included providing places of interest for people who enjoyed walking around the premises. For example, themed areas. The provision of themed areas was to be assessed by the board of governors.

Staff said communication with the manager was good and there was an open culture where information was shared. We were told at the staff meetings held monthly they were told about policy changes and learning from incidents and accidents. They said the manager was approachable. One member of staff said "the manager is understanding and approachable." The manager said the style of management was "all cogs in a wheel."

Members of staff were knowledgeable about the vision and values of the home. Staff told us treating people with respect and dignity was a value of the home. Another member of staff said giving people choice ensuring they were respected and received good quality of life. A third member of staff said "we provide the best care we can. The aim is to promote independence and deliver personalised care to people." The manager said the aim was to keep people well and to care for people as individuals. We saw a "dignity tree" was used for staff to post on the tree their definitions of dignity which informed people, their relatives and visitors the values which underpinned the delivery of care to people.

A registered manager was 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 2008 and associated Regulations which corresponds to the the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Audits of accidents and incidents were used to identify trends and patterns. Other audits such as care plans, medicines and training were used to assess standards were reached and where they were not fully met action was taken. We saw from the most recent infection control audit the waste bins were replaced.

The manager told us there was a house committee made up of members of the public with an interest in the home and their visits were monthly to check on the quality of the service provided to people. A board of governors made up of professionals local to area and their role was to develop the business plan and monitor the risk register. For example staffing levels, finances and the environment.