Barchester Healthcare Homes Limited

Wimborne

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

This inspection took place on 24 January 2017 and was unannounced.

Wimborne is registered to provided accommodation and support for up to 52 people. At the time of our inspection there were 45 people living at the home, some of whom live with dementia. Accommodation is all on one level with four communal areas, 47 single rooms and 5 double rooms.

At this inspection a registered manager was 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.

Following our last inspection in September 2015 requirement notices were issued for breaches in Regulations 9, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had not ensured person centred care, they had not ensured that all identified risks associated with people's care had been appropriately assessed and plans developed to mitigate such risks. Service user records were not always up to date and accurate. At this inspection improvements had been made and these were no longer a breach.

People were safeguarded from harm as the provider had systems in place to prevent, recognise and report any suspected signs of abuse. Medicines were managed safely and risks associated with people's needs had been assessed with plans developed to mitigate such risks. People could be confident they were being cared for by staff appropriate to do so because the provider operated safe recruitment processes and ensured there were enough staff available to meet people's needs.

Staff knew their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005) and Deprivation of Liberty Safeguards (DoLS) and had applied that knowledge appropriately. They understood the importance of obtaining people's consent when supporting them with their daily living needs. Staff received training and support which enabled them to understand and meet the care needs of each person.

People were supported to have sufficient to eat and drink to maintain a balanced diet. Staff monitored people's health and well-being and ensured people had access to healthcare professionals when required.

People experienced caring relationships with the staff that provided good interaction by taking the time to listen and understand what people needed. People's care was planned in a personalised way and delivered by staff that knew them well. Their support needs were monitored and reviewed to ensure that care was provided in the way that they needed.

A clear complaints policy was in place and people knew how to use this if they needed to. The registered manager responded appropriately to complaints and used committee meetings to engage and listen to

people.

Records had improved and systems were in place to monitor the service and drive improvement. The registered manager was open and staff felt supported in their roles.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were safeguarded from harm as the provider had systems in place to prevent, recognise and report any suspected signs of abuse.

People's medicines were managed safely and risks were regularly reviewed and, where appropriate, acted upon with the involvement of other professionals.

People were supported by sufficient numbers of staff that had been appropriately recruited and had the skills and experience to provide safe care.

Is the service effective?

Good

The service was effective.

Care staff knew the importance of gaining consent and acted upon their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005) and in relation to Deprivation of Liberty Safeguards (DoLS).

People were cared for by staff that had the supervision and training to carry out their roles.

People were supported to have sufficient to eat and drink to maintain a balanced diet and to access health care when needed.

Is the service caring?

Good

The service was caring.

People had positive relationships with staff that knew them well. People were supported to make choices about their care and staff respected people's preferences. They were supported to feel involved and part of the community.

People's privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed prior to admission and personalised plans of care developed following this. Staff responded positively to people's needs and requests.

There was a suitable procedure in place to deal with people's complaints.

Is the service well-led?

Good

The service was well-led.

The management promoted a positive culture that was open and inclusive.

People's quality of care was monitored by the systems in place and action was taken to make improvements when necessary.

Wimborne

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 17 and 18 January 2017 and was unannounced.

The inspection team consisted of an inspector and a specialist nursing advisor.

Before the inspection we reviewed information we had about the service, including previous inspection reports and notifications the provider had sent to us. A notification is information about important events which the provider is required to tell us about by law. We also received feedback from the local authority.

During the inspection we spoke with six people who lived at the home and four visitors. We observed the care and support people received in the shared areas of the home. We spoke with the manager, the manager's line manager and eight staff including care staff, ancillary and activity staff. We also spoke to two external health care professionals.

We looked at the care plans and associated records of eight people, medicines administration records, staff duty rotas, five staff recruitment records and five staff supervision records. We looked at staff training records, records of complaints, accidents and incidents, policies and procedures, safeguarding and quality assurance records.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home and that staff were always available if they needed them. Relatives confirmed they felt their loved ones were safe living at Wimborne.

At our inspection in September 2015 we found that identified risks associated with peoples care had not been appropriately assessed and plans developed to mitigate such risks and this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement notice and received an action plan following this which told us they would be compliant by 31 January 2016. At this inspection we found improvements had been made and this was no longer a breach.

Staff were very knowledgeable of people's needs and the support they required. Various assessments were in place to understand the level of risk associated with people's needs, including falls assessments, assessments of skin integrity and nutritional assessments. Following these assessments plans of care had been developed to guide staff about the person's needs and how risks could be minimised. These were reviewed monthly or more frequently if needed.

At the last inspection we were concerned that behaviours which may present a risk to the person or others had not been assessed and plans developed. At the time of this inspection the registered manager told us no one living at the home presented with these behaviours. We did see care plans which reflected that people may become anxious and the support they needed to reduce this.

Accident and incidents were reported monthly to the provider and we noted high levels of unwitnessed falls were occurring in the home. Assessments of the risk had been undertaken and care plans developed to mitigate the risks. Additional support measures had been implemented where appropriate, such as alarm mats, raised seats and discussions with families to ensure appropriate footwear was purchased. Where necessary external advice had been sought and their recommendations were being followed. The regional manager told us how they had requested the provider's clinical development nurse undertake a review of unwitnessed falls to see if a pattern could be identified.

People were supported by staff who had a good understanding of the types of abuse and how to report this. Staff felt confident any concerns they raised would be dealt with appropriately by the manager and knew how to escalate any concerns they may have to the local authority or the CQC. The registered manager knew how to report concerns to the local authority and the CQC, however at the time of the inspection there were no unresolved safeguarding matters.
Staff were aware of the provider's whistleblowing policy and were confident to use this.

The management of medicines was safe. Medicines were stored safely. The clinical room had a coded lock. The room was only accessible to medicines trained staff. Prescription medicines in colour coded (by time of day) containers in monitored dosage system (MDS) packs were kept in locked trolleys attached to the wall. There was a locked wall cabinet for prescribed drugs. Controlled drugs were stored in a separate locked compartment within a locked cabinet. Medicines such as insulin and eye drops were stored in the

refrigerator. Daily checks were recorded of the clinical room and the fridge temperatures.

MAR (Medicine Administration Record) sheets were accurate and contained no gaps. PRN (as required medicines) protocols were in place. These included details of when a nurse should offer a particular medicine to a person, route and dosage (including minimum time between dosages and maximum dosage in twenty-four hours) and in what circumstances the doctor should be informed.

Two people were taking a medicine which thinned the blood. These people's blood required monitoring as a result of this medication. Their records showed this was done safely. These records contained test results, subsequent scheduled tests and the exact dose to administer.

Appropriate recruitment and selection checks had been carried out before staff began work. Applicants completed an application form and were subject to an interview. Following a successful interview, recruitment checks were carried out to help ensure only suitable staff were employed. Staff confirmed they did not start work until all recruitment checks had taken place. We reviewed five staff files. Enhanced Disclosure and Barring Service (DBS) checks had been carried out and numbers issued. References were present, including the previous employer reference (unless the person had not previously been employed, in which case an educational reference was sought, along with a character reference). These help employers make safer recruitment decisions to minimise the risk of unsuitable people from working with people who use care and support services.

People felt staff responded promptly to their needs. Staff told us there were enough staff to meet people's needs. A senior member of staff told us "Oh yes, we've always got enough staff. The girls will pick up extra" (hours). The registered manager and provider used a dependency tool to assess the number of staff needed in the home to meet the needs of people. This was reviewed as people's needs changed or monthly. Care was arranged in day shifts of 0800-1400 and 1400 to 2000, and nights of 2000-0800. The service had a complement of five care staff (including a team leader and a senior carer) on the morning of our inspection. They were supplemented by the Head of Care, an activity co-ordinator, the registered manager, administration, housekeeping, kitchen and maintenance staff. People had call bells within reach in their rooms. Some people we spoke with were unable to operate a call bell so staff carried out regular checks to enhance safety. Observations throughout our time in the home showed staff responded quickly to people's needs and requests, and had time to spend with people.

Good

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

For some people their consent forms for the use of photos had been signed by family members who the registered manager was unable to demonstrate held the appropriate legal authority to provide this. The registered manager told us they would ask the families to provide copies of this. They told us, staff confirmed and we observed that people could make their own decisions about day to day tasks and care plans provided guidance to staff about how to support people to do this. For example, one person's care plan clearly documented where items should be placed to ensure the person could see them to make a choice.

Staff showed a good understanding of consent. A care staff member told us that a person with dementia might make every day choices such as what to wear, what to eat and whether to take part in activities offered. Another said personal care was given with consent. "We offer a wash, we don't force them. Each time somebody declines, it's recorded." A third was able to cite key principles of the Mental Capacity Act 2005 (MCA) such as the assumption of capacity for an adult and the importance of making decisions in a person's best interests when they lacked capacity.

Where more complex decisions needed to be made such as being able to leave the building unsupported, mental capacity assessments had been completed and families had been involved in agreeing the support needed. We noted however that these decisions were not incorporated into any care plans or risk assessments.

Senior staff we spoke with were aware of the Deprivation of Liberty Safeguards (DoLS) accompanying the Mental Capacity Act 2005. The registered manager tracked the progress of applications and authorisations.

New staff spent an initial period of training and undertook a period of shadowing prior to working independently. The manager confirmed any staff who were new to care, were required to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and

behaviours to provide compassionate, safe and high quality care and support.

Staff completed mandatory training and updates including safeguarding, moving and handling, fire safety and infection control. Some training such as moving and handling was delivered practically. Care staff we spoke with had completed mandatory training and further training. Additional training included subjects such as dysphagia (difficulty swallowing), choking, catheter care and pressure ulcer prevention. Staff spoke positively about the training they received and said this was useful to them in their role.

Supervision was carried out individually and in groups. Staff we spoke with told us they received regular supervision, including one to one meetings. A care staff member told us "They ask if you want more training, how you are coping." We saw records of recent supervisions for eight staff earlier in the month. The manager told us that staff had a total of six to eight supervisions annually including individual and group sessions and an appraisal.

People spoke highly of the food and said they were given plenty of choice. They told us and we observed that if they didn't want what was on the menu they could have something different.

On the day of our inspection, a care staff member attended training at a local surgery for their role as 'nutrition and hydration' champion for the home. The chef was the lead for nutrition in the home. The manager told us how they had worked closely with external professionals on this subject area. The chef was familiar with the malnutrition assessment tool (MUST) and used it in assessments of people at risk. They were aware of the need to weigh people at the same time of day to maintain consistency of recording. There were weekly meetings between the chef, people and their families to discuss choices, menu planning, preferences and special occasion food. The chef told us if they were at another home, they would set up a phone conference. They said dietary requirements were "tailor made" to meet an individual's preferences. Kitchen staff were very aware of different food groups and how these helped to maintain or increase weight. For example they explained that high protein given in small frequent meals was better at helping increase weight, than increasing carbohydrate or fat which can be harder to digest for the elderly. They were aware of the effect of age, ill health and dementia on appetite changes. For example, increasing protein which was easily digested, portion size, (too much on a plate can seem overwhelming), colour, flavour and the preference for sweet food.

All food was freshly prepared and staff had guidance about how to ensure the consistency of food and drinks were correct to meet people's needs. The kitchen staff were provided with information regarding people's nutritional needs by the care or nursing staff on a daily basis. The kitchen held a list of people's preferences and needs. The kitchen staff were able to explain how they catered for specific diets.

Monthly assessments of people's nutritional status were undertaken using the Malnutrition Universal Screening Tool (MUST). 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. People had care plans in place regarding their nutritional needs.

Records showed health and social care professionals visited the service as and when required and that requests for their support was taking place much quicker than at our previous inspection. Care records held feedback from GP's, speech and language therapists, social workers and occupational therapists. Staff identified people's needs and involved health and social care professionals appropriately.

Senior staff told us the community matron had visited on the previous day to review people's needs in several areas including nutrition, falls and tissue viability. An external healthcare professional told us that the working relationship with the home was "really good" and that staff were receptive to advice "They

always listen." Staff at the home ensured that care plans and equipment such as dressings were available for district nurses.

Good

Is the service caring?

Our findings

People and their relatives consistently described to us a caring, supportive and kind service. One person stated "This is a lovely place", "A very happy place", "Such nice people". "I am very comfortable here, they are always nice to me". A relative stated," My (mum) has been here for a few months staff are brilliant, all of them, mum gets treated like she is in her own home". Another told us, "It's just like a family here, nothings too much trouble".

People told us they enjoyed living at the home and that staff were kind and caring. A person told us their care was "fabulous".

A senior member of staff told us "We try to be as person-centred as possible. All the carers that work here try their hardest to be person-centred." A staff member told us "It's very caring. What you see is what you get."

The registered manager had a 'hands on' approach and demonstrated a deep understanding of people's needs. For example we discussed care of some of the people at the home. The registered manager was able to discuss in detail their care needs and personality of the person we discussed. Care staff were knowledgeable of people's life histories and preferences. They demonstrated a commitment to ensuring people received the support they needed in a dignified manner. One staff member who was due to be off duty arrived at the home to ensure a person could be supported to attend a hospital appointment. We observed many examples of positive interactions between staff and people who use the service, for instance talking with a person about their earlier life and career. During the inspection one person became unwell and staff had to call the emergency services. They dealt with it in a rapid and professional manner. The process was carried out sensitively and effectively to minimise distress to the person and others living at the home. Privacy screens were deployed by senior staff at the home so that the person's departure from the home was discreet, dignified and did not disrupt the care of others.

The registered manager and staff told us that it was important that people saw Wimborne as their home. They did this by ensuring staff encouraged people to be involved and felt valued. For example, one person was responsible for ensuring the tables were laid and menus were placed.

Whilst staff members spent time during meals helping those who required support, other staff ate their meals with people, engaging in day to day chit chat, laughing and joking with people and their relatives. People's family were welcome at any time. The registered manager told us how they had supported one person's very large family to have Christmas day with their loved one. They had done this in a way that enabled the person to enjoy quality time with their family but did not disrupt other people. A relative said "We often have family dinners here, it is nice to get together, staff are really accommodating nothing is too much bother". A small kitchenette area had been installed since our last inspection, allowing people and their relatives to help themselves to drinks and snacks throughout the day.

The registered manager told us how people were encouraged to be part of the local community. They told us that people had wanted to support a homeless charity over the Christmas period. People were supported

by staff to collect items to donate and some people chose and were supported to make scarfs for the homeless which were then delivered to them.

A relative resident committee had recently been set up and the registered manager told us this was led by one person living at the home. A relative and the registered manager told us the committee enabled people to raise any concerns they may have but also enabled relatives to do this on behalf of those people who may not feel comfortable to share their concerns with staff. The home also ran a monthly church service for those who wished to attend, details of which were placed in visible communal areas. People who lived at the home had the choice to sit and spend time on their own or had the freedom to move around the spacious premises. This meant people could spend time in private when they chose to.

Staff had an understanding about the principles of dignity in care. We observed many examples during the inspection visit of staff talking with people as equals, discussing the day and talking at eye level. Staff would crouch down to speak to people in wheelchairs or seated to gain eye contact and communicate at a face to face level. They explained what they were doing when they supported people and gave them time to decide if they wanted staff involvement or support. Staff spoke clearly but discreetly and repeated things so people understood what was being said to them. Staff supported people in an unhurried manner during activities, mealtimes and with personal care. When speaking with people they used physical touch to reassure them. People had a choice about everything they wanted to do.

Good

Is the service responsive?

Our findings

People spoke positively of the care they received. Relatives described how staff responded to people's needs and provided care and support in a person centred manner. Staff were able to tell us about people's hobbies and interests, their previous lifestyles and their likes and dislikes.

At our inspection in September 2015 we found that the care of service users was not always planned in a manner that met their needs and reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement notice and received an action plan following this which told us they would be compliant by 31 January 2016. At this inspection we found improvements had been made and this was no longer a breach.

Care plans had been developed following a preadmission assessment and were individualised to reflect the person's preferences and needs. For example, one person described how it was important that when staff supported them to get dressed/undressed that tops were not removed over their head. Another person reflected the importance to them of dressing nicely, wearing jewellery and make up. We observed this person looked well-groomed and dressed. People and their relatives were involved in the development of care plans and reviews of these took place regularly. One relative said "We are involved in our relatives care, the care plan review is discussed with us, we usually do this every six months. If there is any change we get told straight away".

Relatives told us how staff had responded to their loved ones needs in a positive manner. For example, one relative told us how staff had offered a change of room due to the noise of other people. The person chose their room and as a result of the move more of the person's own furniture could be utilised. The relative said "It looks like [their] old living room, it's more like home".

A second relative told us how their loved one could become distressed at times. They talked to us about how the staff had suggested the use of dolls as a form of therapy. Dolls, clothing and a cot had been purchased. The person carried the doll with them and viewed this as a baby. The relative told us this really worked for their loved one and helped the person to have a focus and role.

The registered manager told us of some of the things that had changed as a result of listening and responding to people, including the introduction of a salad bar, rather than the kitchen plating up salads for people. Some male residents had developed a gentlemen's group/club and they had evenings when staff would create a "pub atmosphere" and bar in one of the communal areas. These gentlemen could choose pub type meals such as fish and chip suppers for those evenings. One said "I enjoy the pub nights, we can choose our food and have a drink. Sometime we will play records or have a game of cards".

People's changing care needs were identified promptly and were reviewed with the involvement of other health and social care professionals where required. Staff confirmed any changes to people's care was discussed through the shift handover process to ensure they were responding
to people's care and support needs.

A variety of organised activities were available for those who wished to join in, every day between 11am and 5pm. These took place in a variety of communal areas around the home. Sunday was free of organised activities. The registered manager said that as more families and friends were able to visit on a Sunday they felt it better to not have formal activities. Family events/parties were arranged including fetes, fairs, teas and barbeques. In addition singers and entertainers also visited. One relative said, "These events make it more fun ..... makes it more like a home". During the day we saw people engaged in different activities including, knitting, quizzes, watching TV and listening to the radio. Visitors also joined in this created a welcoming, warm and engaging environment.

A complaints procedure was in place and people and their relatives knew how to use this. People and their relatives were confident to speak to the manager and staff to raise concerns and records confirmed they did so when they felt necessary. A complaints folder was maintained which held a log and supporting documentation about the nature of any complaints, how these were investigated and the outcome of these.

Good

Is the service well-led?

Our findings

Staff told us that they felt well supported and that senior staff were approachable. A staff member told us they felt the home was well led and said "You can talk to anyone." A senior member of staff told us they were "Well supported by the care staff as well as my peers". Relatives and people said that the manager was friendly, visible and approachable.

At our inspection in September 2015 we found that service user records were not always accurate and complete. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement notice and received an action plan following this which told us they would be compliant by 31 January 2016. At this inspection we found improvements had been made and this was no longer a breach.

Care records for service users had improved and reflected their needs. Senior staff were in the process of undertaking six month reviews with people and their relatives. Any changes to care records were being made at the time of our visit.

At our inspection in September 2015 we recommended the provider review their quality visits to ensure that all aspects of these are effective at all times.

The regional manager told us how the provider had recently restructured the local area to streamline support provided to the homes. The regional teams now included a quality improvement specialist, a regional trainer and a clinical development nurse. At the time of our inspection the role of quality improvement specialist was being recruited to. They told us that a new audit system was to be introduced which would be led by this role and would result in a red, amber, green (RAG) rating. This was to enable to provider to ensure they focused additional support in services that required this and used other services to learn from.

People were supported by a team of staff that had the managerial guidance and support they needed to do their job. People benefited from receiving care from a team that worked well as a team and were enabled to provide consistent care.

The provider ensured that the registered manager was supported in their role by a regional manager, clinical development nurse and by being involved in shared learning with other home managers with the same provider. In addition, within the home the registered manager ensured that care staff were also supported by senior care staff, team leaders and a head of care. The management promoted a positive culture that was open and inclusive. All staff were clear in their roles and responsibilities. Regular staff meetings took place and these enabled staff to discuss and share any concerns or ideas they may have.

A number of auditing systems were in place to assess the quality of the service provided. This included feedback surveys from people, relatives, staff and other professionals. The results of these were collated by a

central team and then shared with the homes. At the time of the inspection the registered manager had not received the results of the surveys for Wimborne.

Regular clinical governance information was collated and shared with the clinical development nurse who then analysed the information, and produced a report with actions for the registered manager and staff to take forward. In addition a clinical development nurse for the provider visited the home and reviewed any progress made on the actions they had set, audited a sample of care plans and set further actions. The registered manager also undertook an audit on a sample of care plans on a monthly basis and provided actions for the head of care to take forward. We saw the head of care working on these at the time of our inspection.

Random unannounced visits to the home by the management team took place at a variety of times. These looked at areas such as staff uniform, safety checks, medicines records and general observations.

The provider's regulation team and regional management team also undertook audits of the service provided. Following these the team provided the registered manager with an action plan, which was incorporated into the homes central action plan. The central action plan could be accessed by senior management at any time and they could send an alert to the manager and more senior staff including the chief executive officer, when actions had not been completed within the allocated timescale. Once completed the actions were then signed off.