Methodist Homes

Warde Aldam

Inspection report

Westfield Lane
South Elmsall
WF9 2JX
Tel: 01977 643697
Website: www.mha.org.uk

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Ratings

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

Overall summary

The inspection of Warde Aldam took place on 15 October 2015 and was unannounced. At the last inspection on on 25 June 2014 we found the provider met the regulations we reviewed.

Warde Aldam is a nursing home currently providing care for up to a maximum of 60 older people. The home has three distinct units providing care and support for people with nursing and residential needs including people who are living with dementia. Each of the three units has its own communal space and access to a secure garden area. On the days of our inspection 55 people were living at the home.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People we spoke with told us they felt safe. The registered manager and the staff we spoke with understood what constituted abuse and understood their responsibility in keeping people safe from the risk of harm or abuse.

Summary of findings

Risk assessments were in people's care plans and these were reviewed at regular intervals. Where people required staff support for pressure relief, the records were not always an accurate reflection of the time this support was provided.

Recruitment procedures were thorough, this included completing a number of checks prior to candidates commencing employment to make sure they were suitable to work with vulnerable adults.

Procedures for the storage and administration of medicines were safe.

Staff received regular training and supervision to ensure they had the skills to perform their role.

Where people living at the home had their liberty restricted, an authorisation was in place to ensure this was lawful and their rights were protected.

People told us they enjoyed the food. Staff offered people a choice of what to eat and drink and provided support to people where this was required.

Everyone we spoke with said the staff were caring. During our inspection we heard staff speaking to people in a respectful manner and providing care and support to people in a way which did not compromise their dignity.

An activities organiser was assisted by a number of volunteers who supported people to engage in social interaction and participate in the various activities within the home.

People's care plans were detailed and person centred. They recorded people's preferences and support needs and were reviewed at regular intervals.

Complaints were recorded, investigated and analysed.

The registered manager had been employed at the home for two years and they felt supported in their role. Regular audits were completed to ensure the safety and welfare of people who lived at the home.

Regular meetings were held with the staff and relatives to enable two way feedback regarding the performance of the home.

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 not always safe.

Records of people's pressure relief were not always accurate.

People told us they felt safe.

Medicines were stored and administered safely.

Requires improvement

Is the service effective?
The service was effective.

Staff received training and support. New staff received an in-depth induction.

People's consent had been obtained in relation to sharing confidential information and taking photographs.

People spoke positively about the food they received. We observed people received support from staff to eat and drink.

Good

Is the service caring?
The service was caring.

People told us staff were kind and caring.

We saw staff treated people with dignity and respect.

People were supported to make choices.

Good

Is the service responsive?
The service was responsive.

There were a variety of activities provided to engage people.

People's care records provided detailed information about their care and support needs.

There was a complaints system in place.

Good

Is the service well-led?
The service was well led.

There was an experienced registered manager in post.

The registered provider had a system in place to monitor the quality of service people received.

People who used the service, their representatives and staff were asked for their views about their care and treatment.

Good

Warde Aldam

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 15 October 2015 and was unannounced. The inspection team consisted of three adult social care inspectors, a specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this occasion had experience in caring for older people.

Prior to the inspection we reviewed all the information we held about the service. We also spoke with the continuing healthcare team. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spent time in the lounge and dining room areas observing the care and support people received. We spoke with four people who were living in the home and eight relatives of people who lived at the home. We also spoke with the support manager, the registered manager, two unit managers, two nurses, three care staff, the administrator and a volunteer. We also spent some time looking at nine people's care records, three staff recruitment and training files and a variety of documents which related to the management of the home.

Requires improvement

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe or they felt safe leaving their family member in the home. One person said, "I feel safe. They make sure the doors are locked and they keep coming round checking on everybody." A relative said, "(Person) is a lot safer here than they were at home with me. (Person) has got everything they want."

We saw from the registered provider's training records that all staff had completed safeguarding training. Staff we spoke with also told us they had completed safeguarding training and were able to identify different types of abuse and understood their role in relation to reporting any incidents or situations which may put people at risk of harm. The registered manager told us they were confident in their knowledge of what constituted a safeguarding concern..

Each of the care plans we reviewed contained a variety of risk assessments. These included moving and handling, falls, nutrition and pressure care. Specific risk assessments were also in place which pertained to the particular equipment people required, for example, bed safety rails and shower chairs. Risk assessments were reviewed and updated on a regular basis. This meant people's care and support was planned and delivered in a way that reduced risks to their safety and welfare.

Where people were identified as being at risk of developing pressure sores staff completed a pressure relief chart. This documented the date, time and detailed how the person's position was changed. We saw two examples where these records were not always an accurate reflection of pressure relief people received. For example, we saw one person's record detailed 'standing' at 08.00 and 10.45 but we saw staff did not assist this person to stand and transfer into an easy chair until 11.10. The pressure relief chart also detailed they required the use of a pressure relieving cushion but we noted this person had been sat in a wheelchair without a pressure cushion. A second person's pressure relief chart recorded 'hoisted' at 08.45 and 10.30 but we saw this person sat in a wheelchair at 10.30 and staff did not transfer them to an easy chair until 11.05. This evidenced that records were not always an accurate reflection of the time people received support from staff.

We saw fire evacuation slings were located at various points around the building. This equipment is required to assist people who have mobility problems in the event they have to be moved urgently. A file was kept in the reception area which included a personal emergency evacuation plan (PEEP). This is a document which details the safety plan, e.g. route, equipment, staff support, for a named individual in the event the premises have to be evacuated. Regular checks were made on the fire detection system, emergency lights and fire extinguishers. This showed us the home had systems in place in the event of an emergency situation.

Records were kept of internal maintenance checks carried out within the home. This included monitoring of water temperatures, nurse call points and wheelchairs. A matrix was in place which identified when equipment was due to be serviced.

We asked one staff member how staff dealt with situations when people's behaviour escalated. They said staff had been trained in non-harmful methods of control which included guiding; safe holds and escorts. The staff member told us, "If you know people well you can see signs of escalation and distract and calm people before agitation increases." One care plan we looked at recorded the person could be resistive to staff support in certain situations. We spoke with a nurse who confirmed the training staff received and told us this was written into the care plan to ensure there were clear instructions for staff in the event the person was resistive to staff support..

Each of the care plans we reviewed contained a falls risk assessment and a falls diary. In one of the files we looked at we saw that when the person had a fall, the falls risk assessment was reviewed and updated. A copy of the accident form was retained in the care plan file. We saw a monthly analysis was completed for all recorded accidents. We asked the registered manager if any trends had been identified from the analysis. They said they had identified an increase in falls in the evening and as a result the night staff numbers had been increased from four to five staff. This demonstrated the registered manager made changes to the operation of the home where an issue was identified.

We looked at three staff files and saw candidates had completed an application form, notes were kept of the interview and references obtained. One of the staff files we reviewed was for a member of nursing staff and we saw evidence the registered provider had confirmed their professional registration was current. This showed the provider had ensured staff members were continuing to

Requires improvement

Is the service safe?

meet the professional standards that are a condition of their ability to practise. Potential employees had been checked with the Disclosure and Barring Service (DBS) before they started work at the home. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. We noted the DBS for one of the staff files was dated June 2008. Although it is not mandatory that these checks are renewed, we could not see any evidence that ongoing suitability of staff was monitored and verified to ensure they remained suitable to work with vulnerable people.

In the reception area the photographs, names and designation of staff were displayed on a notice board. This enabled people who live at the home and visitors to be able to clearly identify staff employed at the home and their function within the organisation.

We asked people if they felt there were enough staff at the home. One person said, “You never know who's coming on at night, they use a lot of agency staff." Two relatives said, "Staff are on hand all the time," and, "There are always a lot of staff around." One relative we spoke with expressed concern regarding staffing on an evening. They said people were not always available in the communal areas due to staff supporting people with personal care. Three of the staff we spoke with said they thought the home needed more staff. One staff member said, “Only a few people need the assistance of one staff, all the others need two staff. It makes it difficult to assist everyone.” Another staff member said they felt the staffing was not an issue but they added they felt this was because there were a small number of vacant beds at the present time.

The registered manager told us the staffing budget was planned around the occupancy of the home. They said the registered provider was flexible in their approach to this and a recent request to increase staffing numbers had been approved.

Medicines were stored appropriately and were locked away securely to ensure that they were not misused. There was an effective system of stock control in place and this reduced the risk of people running out of their medicines and minimised the amount of medication wasted.

We saw a monitored dosage system (MDS) was used for the majority of medicines while others were supplied in boxes or bottles. We checked a random sample of medicines and found the stock tallied with the number of recorded administrations. We also checked four medicines which were stored in the controlled drugs cupboard. The stock tallied and each entry was completed and checked by two staff. We observed a nurse administering medicine to people and this was done safely. For example, as the nurse dispensed each medicine they made a small dot on the individual medication administration records (MAR) but did not sign the MAR until after the medicine had been administered to the person.

We reviewed one person who required analgesia ‘as required’ (PRN). A care plan was in place which informed staff of the circumstances the medicine may be administered and the signs staff should observe for to indicate the person was in pain. We saw another person was prescribed a PRN medicine to help staff manage their behaviour. The care plan recorded this medicine was only to be used when other methods, for example, de-escalation, had not worked. This showed staff were not relying on medicines to manage people’s behaviours.

Medicines were only handled by staff who were trained. The training matrix evidenced staff who administered medicines received regular training and an assessment of their competency.

Good

Is the service effective?

Our findings

One of the staff we spoke with told us there was a daily handover between staff. Another staff member said they felt the handover 'equipped them for the day.' We saw staff completed a written handover document which was then retained for future reference. Effective handovers are essential to ensuring staff have all the relevant information they need to enable them to support people safely and effectively.

All the staff we spoke with told us they received regular supervision with their manager. One staff member said the supervision was an opportunity to 'reflect and discuss any issues.' All the staff we spoke with said they felt supported in their role and could raise concerns with the unit managers or the registered manager.

One of the staff we spoke with told us how they had been supported when they commenced employment at the home. They said they had shadowed a more experienced staff member for two weeks as well as completing a structured programme of induction. We saw documented evidence staff had completed a formal induction in each of the staff files we reviewed. This demonstrated new employees were supported in their role.

Staff also told us they completed regular training in a variety of topics. This included, moving and handling, fire, infection prevention and control and health and safety. The registered manager told us training was delivered by e-learning. After the inspection we reviewed the registered provider's training matrix and saw this evidenced when staff had completed training and when they were due to update their knowledge. One of the courses listed provided staff with the knowledge and skills to support people whose behaviour may challenge others. The matrix indicated this was to be refreshed annually. We saw 36 of the 50 staff for whom this training was required had not completed refresher training for over a year. When we asked the registered manager about this they told us this had already been identified as an area which required attention.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS) within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager told us they had completed training with the local authority regarding the MCA. We also reviewed the registered provider's training matrix and saw that only five of the 80 staff listed had not yet completed this training. However, the matrix recorded that a refresher was not required for this training. Ensuring staff receive regular updates to their training means staff have up to date skills and knowledge to enable them to meet people's needs in line with current standards of good practice.

The registered manager showed us a file which contained documents relating to the DoLS applications which had been submitted for people who lived at the home. We saw a matrix which detailed the name of each person who was living at the home who had a DoLS authorisation in place and when it was due to expire. This ensured people who were deprived of their liberty, were done so lawfully and their rights were protected.

The care plans we reviewed recorded the decisions people were able to make independently. We saw one person's care plan recorded they lacked capacity to make decisions relating to their personal hygiene needs. The care plan included a mental capacity assessment and a detailed care plan which recorded the action staff were to take.

We saw consent forms had been signed in each of the care plans we looked at in relation to photographs, medication and sharing of confidential information. As the forms did not record the designation of the person who had signed it, we could not clearly evidence if the form had been signed by the person who lived at the home or their representative.

Every person and relative we spoke with was positive about the food served at Warde Aldam. One person said, "The food is good. It's well cooked as well. If you don't like what's

Good

Is the service effective?

on the menu you can have what you like. I have brown toast with butter and marmalade every morning in bed." A relative said, “The food is lovely. Sunday lunch is always a proper Sunday lunch."

When we first went on one of the units we saw some people were still eating breakfast. We saw staff were available to assist people in an unhurried way. A staff member asked, “Do you want tea, coffee or fresh orange juice?” We saw someone who had already eaten, ask for some more and this was promptly provided..

We observed lunchtime on each unit. People ate their lunch in the dining room, lounge area or their bedrooms. Staff offered people a choice of tea, coffee or juice. Interactions between staff and people were relaxed. Where people required support to cut their food or to eat, this support was provided. We observed one staff member assisting a person and they told the person what the food was before they put it in their mouth. We heard another staff member say, “I’ve not put a right lot on your plate because I didn’t want to over face you.” One person said they did not want what was on offer and asked for a bacon sandwich, which was provided without fuss. At the end of the meal one person was offered a pint of beer which they drank with enthusiasm.

We looked at a random sample of eating and drinking records. These recorded what people were offered as well as what they consumed.

We saw documented evidence in people’s care plans that they received input from other healthcare professionals. For example, general practitioner, district nurse and speech and language therapists. This showed people using the service received additional support when required for meeting their care and treatment needs.

Good

Is the service caring?

Our findings

Everyone we spoke with was very complimentary about the staff. One person said, "The nurses are good. 10 out of 10." A relative said, "The staff here are absolutely fantastic. They are kind and supportive. “Another relative said, "It's absolutely bang on. The staff are lovely and the atmosphere is great."

Staff told us they enjoyed working at the home. One staff member said, “I really enjoy working here, the staff are caring and the service users are lovely.” When we asked staff for information about people who lived at the home, they were knowledgeable about people’s needs and abilities.

Throughout the period of time we spent at the home we observed staff to be consistently kind and caring and interactions between staff and people who lived at the home were respectful. People who lived at the home were relaxed and comfortable in the presence of staff. One person was brought into the dining room in a wheelchair singing ‘Underneath the Arches.’ Other people and staff also joined in.

We heard staff providing reassurance to people when they were unsure of their location or surroundings. We observed one staff member listen patiently before providing appropriate comfort to the person. A staff member was heard talking to a person in their bedroom. We heard them asking if the person needed anything before they left. The staff member said, “Do you want your table moving any closer? Your buzzer is just there, buzz if you need anything.”

Staff respected people’s privacy, for example they knocked on doors prior to entering. One member of care staff told us they ensured personal care was only carried out when the door and curtains were closed. We observed staff supporting one person who required a hoist to transfer them into a wheelchair. This manoeuvre was carried out safely, staff explained what they were doing and ensured the person’s dignity was maintained.

Staff clearly knew people’s likes and dislikes, but were still heard to offer choices. For example staff asked where people may like to sit or what they would like to eat or drink. At lunchtime we noticed one person could not decide what they wanted to eat. The staff member showed the person the choices available to enable them to make a decision.

Each of the care plans we looked at contained a personal profile and life history document where people’s biography could be recorded. The information in one of the records was limited and lacked the detailed information which enables staff to have insight into people’s interests, likes, dislikes and preferences. Life history can also aid staffs’ understanding of individual personalities and behaviours.

Good

Is the service responsive?

Our findings

We asked relatives and visitors to the home what activities were available to engage people during the day. One person said, "Sometimes we can go along for a singalong." Another person told us they enjoyed going out in the grounds when the weather was suitable. A relative said, “The day after they came in there were three photos of (person), on the wall, dancing and smiling." People and relatives told us activities included singalongs, light exercise, watching films, baking, dancing and entertainers.

Warde Aldam home employed two activities organisers. Their rota had been organised to enable each of the three units to have four hours of activity support five days a week. The home also had a network of volunteers who came to the home on a regular timetable to provide extra activities and social interaction for people. We spoke with a volunteer on the day of our inspection and they said, "I come and do a knit and natter group. I do two mornings a week." .

Each of the care records we looked at contained a variety of care plans, including, personal hygiene, mobility and eating and drinking. Care plans were written in a person centred way and provided details about people’s needs, likes, dislikes and preferences. For example one person’s care plan noted the presentation of their meals was very important to them. The care plan detailed how their food should be presented and why this was important to them.

Having this level of detail in care plans is important as many people who lived at the home had memory impairments and were not always able to communicate their preferences to staff.

Care plans were reviewed and updated at regular intervals. We found the content of individual care plans was reflected consistently throughout all the care record. We asked the registered manager how people and/or their relatives were involved in reviewing their care plans. They said the unit managers invited relatives to a six monthly review of their care plan and an annual review was completed alongside the relevant funding authority. Regular reviews help in monitoring to ensure care records are up to date and reflect people’s current needs so that any necessary actions can be identified at an early stage.

We asked people what action they would take in the event they were unhappy with any aspect of the service they received. One relative said "I'd go and see (staff name) and (staff name) if I had a concern. They say, ‘Right we'll look into it for you’.” Another relative said, "The manager is alright. I'd them if I needed to complain but I've nothing to complain about." When we spoke with one relative they told us they had recently met with the registered manager to discuss a concern they had and they said, “She has responded to our concerns and the problem has been alleviated. It was a great meeting."

We saw evidence formal complaints were logged, investigated and action was taken as a result of complaints being raised. They said analysis of complaints for patterns and trends was completed by head office.

Good

Is the service well-led?

Our findings

People and relatives spoke positively about the home, the registered manager and the staff. One person said, "The manager is alright. She has a joke with me." Another commented, "I wouldn't change anything. I'm happy." A relative we spoke with said, "If I go into a home I would want to come here. I'd recommend anyone to this home." Only one person commented negatively and they said, "Communications could be better between management and families."

A volunteer we spoke with said, “I feel part of the team, they make me feel very welcome when I come."

The home had an experienced registered manager in post who had been employed at the home for two years. They were knowledgeable about the people who lived at the home and their staff. They told us they felt supported in their role and felt it was a good organisation to work for. One of the unit managers we spoke with had a clear vision as to how their unit should operate. They told us they were very clear with their staff regarding how they should conduct themselves in their job. Both the registered manager and a nurse we spoke with told us when they had a vacancy at the home considered the needs of people who were already living at the home and how a new person would fit in.

The registered manager told us they did a daily walk around of the home, talking to staff and people who lived at the home. They said this provided them with an opportunity to observe practices and ensure the home was operating to the standard they expected.

We saw a range of audits were completed to ensure people’s safety and welfare. These included check of the first aid boxes, health and safety, pressure mattresses and care plans. We saw evidence in two of the care plans we looked at that an audit had been completed and any identified issues had been actioned. We also saw audits were completed to identify people at risk of weight loss and pressure ulcers.

The performance of the registered manager was overseen by a service manager. We met the service manager on the day of our inspection and they said they visited the home at least monthly. They said each visit generated a report and they followed up on any concerns at their next visit. The registered manager showed us their most recent report and we saw evidence of where the registered manager had made notes on the report to evidence the action they were taking to address the areas identified for further improvement.

These examples demonstrate there was a quality assurance and governance system in place to drive continuous improvement.

We saw evidence regular meetings were held with staff. These were a mix of general meetings and meetings held with particular groups of staff, for example night staff or ancillary staff. Minutes recorded the names of attendees and the topics discussed.

Notice boards throughout the home provided information for people, relatives and visitors regarding relatives’ meetings and a relatives’ support group. We looked at the minutes from the meetings held in July, August and September 2015. Topics discussed included menus, activities and the current refurbishment programme. At one of the meetings the nurse practitioner from the local general practitioner surgery had attended, talking to people and answering their questions. One relative told us, “They have residents’ meetings every two or three months."

The registered manager said they had set up a support group for spouses and family members who visited the home. They said this was now a regular coffee afternoon. They said they tried to invite speakers, for example a funeral director had come to talk to people and they had invited a representative from an advocacy service to come to a future meeting to talk with people.

A quality survey had last been issued in 2014 and the results were on display in the reception area. An action plan had been generated from the. This showed the registered provider had taken action to address the issues identified in the survey.