St. Martin's Care Limited

Windermere Grange Care Home

Inspection report

Windermere Road
Middlesbrough
Cleveland
TS5 5DH

Tel: 01642815594
Website: www.smcgroup.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service: Windermere Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual arrangement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Windermere Grange accommodates 50 people over two floors and within four separate wings. The service had two specialised services which provided care to people living with dementia and care and support for people with learning disabilities.

The learning disability service was situated off the main residential home with its own secure entrance. At the time of the inspection there were 14 people living in the service. The size of this service is larger than current best practice guidance. However, this did not have a negative impact on people due to its design and how it was discreetly positioned away from the main residential care home.

What life is like for people using this service: Since our last inspection the provider had failed to maintain consistent high quality standards of practice within the service.

Medicines were not always managed safely; quality monitoring systems had not picked up on areas of improvements required.

Outcomes for people living in the learning disability service did not fully reflect the principles and values of Registering the Right Support; people lacked choice and control over their lives and had limited inclusion in meaningful activities.

Staff raised concerns regarding low staffing levels within the residential care service at certain times of the day.

Care and support plans were not always person-centred and did not reflect people's specific needs and future goals.

Risks to people's health were not always assessed to provide staff with the necessary guidance on how to keep people safe.

Staff did not always follow the providers infection prevention and control procedures; they did not use personal protective equipment (PPE).

Some people's dietary needs were accurately recorded. Referrals to speech and language therapy (SALT) were made when required.

Staff received training in line with the providers policy. Some staff needed specific training to support people with learning disabilities. We have made a recommendation for this training to be provided so staff can positively support people who have a learning disability.

The service's quality assurance process was not robust as audits failed to identify the issues we found on our visit.

Staff stated they felt supported by the registered manager. Complaints procedures were in place to address any issues raised at the service.

The service worked with other organisations and agencies to promote people's health and wellbeing. People had access to their GP or health professionals when needed.

Rating at last inspection: Good (last report published 22 February 2018).

Why we inspected: This was a planned inspection following the opening of a new learning disability service in December 2018.

Action we told provider to take: We identified three breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 around person-centred care, safe care and treatment and good governance. Details of action we have asked the provider to take can be found at the end of this report.

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

For more details, please read the full report which is on the CQC website at www.cqc.org.uk.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Windermere Grange Care Home

Detailed findings

Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: Two inspectors, a medicines specialist and an expert by experience carried out the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: The service is a 'care home'. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.'

Notice of inspection: This was an unannounced inspection.

What we did: Before the inspection we reviewed information, we held about the service in the form of statutory notifications received and any safeguarding or whistleblowing incidents which may have occurred. A notification is a record about important events, which the provider is required to send us by law.

We used the information the provider sent to us in the Provider Information Return (PIR). This is key information providers are required to send to us about their service, what they do well, and improvements they plan to make. We also contacted the local authority and their safeguarding team and the local Healthwatch to gain their views. Healthwatch is an independent consumer champion that gathers and

represents the views of the public about health and social care services in England.

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

We spoke with 10 people who used the service and five relatives about their experience of the care provided. We spoke with eight members of staff, one activity co-ordinator, the chef, one senior staff, two deputy managers, the registered manager, head of care and the quality manager. We reviewed eight people's care and support files, 14 people's medication administration records (MAR's) and four staff recruitment files. We also looked at a sample of the service's quality assurance systems, the registered provider's arrangements for managing medication, staff training records, staff duty rotas and complaint and compliment records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Preventing and controlling infection.
• Care and support plans did not record people's current needs. Risk assessments lacked guidance to alert staff what to look for and how to support people with specific health conditions.
• Staff were not provided with guidance on how to support people who displayed behaviours which others may see as challenging. Guidance was based on the management of behaviours rather than supporting people to learn positive coping skills.
• Information regarding people's dietary requirements was not always accurate. People's care and support plans did not reflect the recommendations provided from health professionals.
• The provider had systems to promote good standards of infection prevention and control. However, staff applied cream to one person's body without following these procedures or using protective, disposable gloves.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – safe care and treatment.

Using medicines safely.
• Medicines were not always managed safely.
• Records for the application of people's creams and ointments did not provide staff with clear instructions of where on the person's body they should be applied or the frequency. Medicines that come in the form of a patch did not have instructions directing staff to apply on different parts of the body to prevent people suffering side effects.
• Procedures were not always followed for people who lacked capacity to make decisions about their medicines which were being administered without their knowledge or consent. Staff did not always discuss how these were given with other agencies to ensure these were being managed correctly.
• Records for medicines prescribed to be given when required did not give staff enough information as to when they should administer them for the person. Records did not always show why these medicines had been given or if they had been effective.
• The medicine audit process was not robust; poor practice was not being picked up quickly and improved.

The lack of robust management of medicines meant people were at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – safe care and treatment.

Staffing and recruitment.
• Staff told us at certain times of the day they felt there was not enough staff on duty to safely meet people's

needs. Comments included, "Staff levels are ok down here but I think upstairs [Dementia specialist service] could do with more staff as they sometimes need to borrow from us which can leave us short." The provider took immediate action to review how and where staff were working during peak times of the day to ensure there were enough staff present to keep people safe.
• Auditing systems failed to identify if recruitment procedures had been followed. For example, there were gaps in two staff member's employment history records which had not been investigated and no pre-employment checks at all for another staff member.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong.
• People and their relatives said they felt the service was safe. One person said, "I feel very safe, I don't lock my door and every time I press my buzzer staff come straight away."
• Staff received safeguarding training and said they would not hesitate to report any concerns they had.
• Effective arrangements were in place to learn lessons when things went wrong.
• Where accidents and incidents had occurred, these were analysed and acted on to identify trends and reduce reoccurrences.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not been met.

Ensuring consent to care and treatment in line with law and guidance.
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
• Where people were being deprived of their liberty, applications had been made to the Local Authority for authorisation and DoLS records were up to date.
• Care and support plans did not accurately record people's consent had been sought. In some records relatives had given signed consent when they may not have the appropriate legal authority to do so.
• One person had been assessed as both having mental capacity and lacking mental capacity. The registered manager immediately addressed this.
• Staff asked for people's consent before providing care and support. Most people were supported to make their own decisions.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet.
• People did not always receive the support they needed. One person received no support or encouragement from staff to eat their breakfast. Staff removed this from the person uneaten with no explanation, resulting in them becoming distressed.
• Care and support plans contained some person-centred information but the amount of detail varied between the services. There was lack of independent life skills learning planned.
• Assessments were not always updated as people's needs changed.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

• People were supported to have choices for meals. Most people were very positive about the quality of meals telling us they were lovely.

Staff support: induction, training, skills and experience.
• Staff had not received training in how to support people with learning disabilities or provide positive behaviour support. We recommend the provider ensures all staff working within the learning disability service receive specific training in current best practice on how to positively meet people's needs.
• A staff induction and training programme was in place.
• Staff had opportunity for supervision and appraisal. Staff told us they felt supported.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support.
• The service worked well with other organisations. Records showed staff contacted doctors and other healthcare professionals when needed.

Adapting service, design, decoration to meet people's needs.
• Windermere Grange is a purpose-built care home set over two floors. There was sufficient dining and communal lounge areas for people to use and choose from within the service.
• People's individual preferences, culture and support needs were reflected in the environment and recent adaptions. Reminiscence displays had been developed throughout. People's bedrooms had been decorated specifically to their individual choices and preferences.
• Risks in relation to the premises were identified, assessed and well managed.

Requires Improvement

Is the service caring?

Our findings

Our findings - Is the service caring? = Requires Improvement

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care.
• Staff did not always respect people's dignity, privacy and personal space. Staff did not always use people's preferred names, get down to people's level and give eye contact when talking to those people who could not verbally communicate.
• People's confidential records were not always stored securely; there was an open cupboard containing people's personal information which anyone could access.
• People were not always encouraged to be independent or develop essential, independent living skills. For example, staff did not actively encourage people to make their own drinks and snacks where appropriate.
• Views of people living in the learning disability service were not always sought. Meetings were not taking place to allow people to have their say on how the service was being run.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

Ensuring people are well treated and supported; equality and diversity.
• Whilst people and their relatives told us staff were caring with people, this was not consistent across the whole service. Some people received very little positive interaction from staff.
• People told us, "Staff are kind and caring, I feel looked after and if I need anything there is always someone here."
• Staff knew people very well, and could talk to people about things of interest and importance to them.
• People were supported to maintain relationships and social networks of importance to them.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.
• People's care and support records did not always reflect their current needs or provide sufficient guidance for staff on how needs were to be met.
• Care and support plans required updating so people had goals to achieve. One person told us how they wanted to live independently within the community. We could find no planning of any goals to help this person work towards their aspiration.
• People living in the learning disability service did not participate in meaningful and stimulating activities. For example, one person was simulating knitting but had no wool. Staff were unable to explain why the person did not have wool to enable them to do their knitting.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

• Health and social care professionals and relatives were involved in the planning of people's care.
• The provider understood the need to comply with the Accessible Information Standard (AIS) to make information available to people in a way they could understand it. The registered provider told us they would access such information for people on an individual basis as needed.

Improving care quality in response to complaints or concerns.
• The provider had a complaints procedure.
• People and their relatives knew how to raise concerns. Comments included, "No one will have any complaints, the staff are excellent and caring especially when it comes to safeguarding issues."

End of life care and support.
• Staff were aware of good practice and guidance in end of life care, and knew to respect people's religious beliefs and preferences.
• When required, people would be supported to make decisions about their preferences for end of life care. Professionals would be involved as appropriate to ensure people were comfortable and pain free.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility.
• Quality monitoring and audits had not identified some areas for improvement.
• Improvements were needed to support people positively when they displayed behaviours which could be challenging to others.
• Care and support plans required updating to reflect people's current individual needs
• Audits had failed to identify that people's confidential records were not stored securely.
This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – good governance.

• Staff spoke positively about the management team and the support they received.
• Relatives told us, "Everything is good and it's very person centred so they give everyone quality time, it's very homely and very well managed" and "[Registered manager's name] has an open-door attitude and since they have taken over things have improved incredibly."
• The registered manager had informed CQC of significant events in a timely way by submitting the required notifications. This meant we could check appropriate action had been taken.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.
• Arrangements were in place for gathering some people's views of the service they received and those of people acting on their behalf. This was not consistent across the whole service.
• Staff meetings were held to give the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service. Concerns raised about insufficient staffing numbers at certain times of the day had not been acted upon prior to our visit.
• Meetings were held for people, their relatives or representatives living in the residential care service at Windermere Grange. However, these were not held in the learning disability service.

Continuous learning and improving care; working in partnership with others.
• The registered manager and provider told us all areas of the service would be continually monitored to ensure compliance with regulatory requirements.
• Discussions were held as part of routine staff meetings to discuss any lessons learned and continuous learning to improve the quality of care people received.
• The management team had established and maintained good links with the local community and with

other healthcare professionals which people benefited from.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to design care and support plans that reflected and achieved people's preferences and life aspirations The provider failed to actively involve people living within the learning disability service to have a say on how the service is delivered

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess the risk to people's health and safety and ensure people received the correct level of care or treatment. Medicines were not always being managed properly and safely to ensure they met people's health needs. The provider failed to prevent and control the spread of infections by staff who did not follow procedures and use of personal protective equipment

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care

governance

The provider failed to ensure suitable arrangements were in place to provide a good quality of care, assess and monitor the quality the service provided