Barchester Healthcare Homes Limited

Wimbledon Beaumont

Inspection report

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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

Summary of findings

Overall summary

About the service
Wimbledon Beaumont is a residential care home providing personal and nursing care for to up to 49 people in one adapted building. The service provides support to older people, including those with dementia and a physical disability. At the time of our inspection there were 44 people using the service.

People's experience of using this service and what we found
Staffing levels at the home were not always consistent in meeting people's needs. People, relatives and staff reported that they felt more staff were needed. We have made a recommendation for the provider to review their staffing levels.

Quality assurance checks required more details to ensure that findings were clear, so that issues could be identified to support developments and improvements.

People were supported by staff that were safely recruited. Staff working at the home knew how to report any potential signs of abuse. Potential risks to people were clearly assessed so that staff were able to mitigate risk occurrence. Medicines were administered to people at the times they needed them and in line with prescribing guidelines.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff received relevant training and support to enable them to carry out their roles. People were well supported with meals of their choosing and to access healthcare professionals when needed. The premises were suitably designed to meet people's needs.

People were well cared for by staff that established a good rapport. Staff treated people with dignity and respect, whilst supporting people to be as independent as they could be.

Activities were planned to help stimulate people. Care records were personalised and allowed people to be supported in ways that met their preferences. Where people expressed their end of life wishes they were supported to do so and their care records reflected this. Complaints and concerns were responded to in a timely manner.

The leadership was visible, and people, staff and relatives felt they were able to raise any concerns they may have. The provider worked alongside other agencies to support continuity of care. People, relatives and staff feedback was sought to help develop and improve the service.

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

Rating at last inspection and update
The last rating for this service was good (published 04 September 2019)

Why we inspected
The inspection was prompted in part due to concerns received about staffing, suitable stimulation for people and the working culture of the home. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

We have found evidence that the provider needs to make improvements. Please see the safe section of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wimbledon Beaumont on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our responsive findings below.	**Good**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Good**

Wimbledon Beaumont

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection was carried out by three inspectors 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 made calls to relatives.

Service and service type
Wimbledon Beaumont is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Wimbledon Beaumont is a care home with nursing. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post. They were not present on the day of our inspection due to personal commitments.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information

providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We also reviewed intelligence information we held on our system including notifications about important incidents.

We used all this information to plan our inspection.

During the inspection
We spoke with the one person living at the home, two relatives, the operations director, the clinical lead, four healthcare assistants, two agency healthcare assistants, two nurses, the administrator and the activities coordinator. We also spoke with the registered manager from their sister service, who was present to support the inspection.

An Expert by Experience spoke with six relatives.

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.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement.

This meant 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.

Staffing and recruitment

- Prior to the inspection we received concerns that there were not enough staff to meet people's needs. We observed that staff were busy and supporting each other in delivering different care functions across the home. In addition, to this the home used regular agency staff. At the time of inspection, some staff members were unable to work as a result of the COVID-19 pandemic.
- Staff told us, "You can see we're struggling" and "We can manage with two [nurses] but it's more difficult, but we do try and help each other sometimes we will get an agency in especially if it gets busy".
- We received mixed views from people and relatives as to the staffing levels. They said, "It is hard to tell at times but I would say they are usually under-staffed" and "Just lately there have not been as many staff around – since after Christmas. It has taken me a while to locate a carer on visits." However, others told us they felt that there were always staff around should they need to find anyone.
- At times we observed people in communal areas with minimal engagement from staff as they were delivering personal care. On the day of inspection additional staff were brought in from their sister home, to enable regular staff at the home to engage with the inspection.
- Records showed that personal emergency evacuation plans (PEEPs) meant that some people required multiple numbers of staff to support a horizontal evacuation in the event of a fire. For example, a PEEP for one person showed three staff members would need to evacuate them. Another person required two staff members. We discussed our findings with the operations director who told us they understood their staffing levels to be sufficient to meet the needs of those living at the home.
- After the inspection, the provider confirmed they had reviewed PEEP records to ensure there were enough staff to manage people's needs and evacuation in the event of a fire. They also told us they had updated PEEPs so that no-one required multiple staff to support them to evacuate.
- We were not assured that current staffing levels were enough to meet people's needs; nor to always allow for periods of meaningful engagement.

We recommend the provider review dependency levels and ensure staffing levels are suitable to meet the needs of people and staff.

- Staff were safely recruited. This included a record of employment history, appropriate references and a Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● Records showed that safeguarding allegations were promptly reported and investigated.

●A staff member said, "I report suspected abuse and document it. If needed you can mark it on the body map. You can take it further to CQC or Local Authority safeguarding – whistleblow."

Assessing risk, safety monitoring and management

● Staff were aware of the risks to people and there were records in place to manage the risk. For example, staff spoke about one person who at times behaved in a way that challenged the service. They told us the community mental health team were involved in this person's support and they had recently come to do a review. There were records in place to evidence this.

● Where people had been identified at risk of harm, there were risk management plans in place to support people and staff to reduce the risk . For example, one person had been assessed as being at high risk in relation to skin integrity. They also had a pressure sore. We saw that the risk assessment for skin integrity was reviewed monthly, they had a wound assessment and wound care and treatment plan in place, with input from the Tissue Viability Nurse (TVN). We saw that their wound had improved. A staff member said, "We worked with the TVN and GP and it so now healing. The TVN has discharged him now."

● In another example, a person had been assessed as being at risk of depression. There was an associated mental health care plan in place.

Using medicines safely

● Medicines practice was safe. We observed a nurse administering medicines and she did this in line with good practice. She cleaned her hands before starting, checked the medicines administration records (MAR) charts against the medicines and locked the medicines trolley if she left it unattended.

● Consent from people was sought before giving them their medicines, and the MAR were signed to show that they had taken them. MAR charts were checked by a second nurse at every handover which helped to ensure that people had been given their prescribed medicines during each shift.

●There were PRN [for 'as needed' medicines] guidelines in place for people and each person had a medicines profile with details of their allergies and their photo. Where transdermal patches were being used, a record of these were kept so that the place of administration was rotated, in line with good practice.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

People were supported to visit the home. This included a current lateral flow test and use of masks when visiting people.

Learning lessons when things go wrong

● Where incidents and accidents occurred these were promptly recorded and investigated so that any lessons could be shared.

● Actions were taken to reduce the likelihood of reoccurrence, such as updates to risk assessments and liaison with appropriate healthcare professionals.

Good

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.

At our last inspection we rated this key question good. The rating for this key question has remained good.

This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed prior to admission. We reviewed care plans for people that had been admitted to the service within the last year. They were pre-admission assessments which were completed before people came to live in the home and a total care assessment which was completed on admission to the home. This helped to ensure that people's needs could be met and any risks could be identified.
●The service used standard, industry recognised tools for any assessments. For example, Waterlow for the risk of pressure sores, Cornell Scale for Depression in Dementia, moving and handling assessments, falls risk assessments and Malnutrition Universal Screening Tool (MUST) to identify people, who were malnourished or at risk of malnutrition (undernutrition).

Staff support: induction, training, skills and experience
● Staff received regular training that was relevant to their roles. We reviewed the provider training matrix and found that training was up to date, with sessions booked where staff required an update on a particular topic.
● Staff told us, "The induction was useful, it tells you about the clients and what's expected of you." Records showed that staff competency was reviewed at regular intervals in areas such as medicines and moving and handling to ensure staff were able to carry out their roles well.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff knew which people were at risk of malnutrition and needed extra support. They said, "These residents are on food link and we give them milkshake." We looked at weight charts for these residents and saw they were maintaining their weight which was recorded monthly.
● Nutritional profiles were developed for people. These included their likes and dislikes for their meals and snacks but also their preferred texture, dietary requirements, allergies and preferred portion sizes.

Adapting service, design, decoration to meet people's needs
● The home was well decorated and well kept, as well as being clean and hygienic throughout. Premises were well maintained.
● There was appropriate signage in place to support people to orientate to communal areas and to their rooms.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● Records showed that people were supported to access other healthcare professionals, and that the home highlighted any changes in need promptly. A relative said, "The carers noted that my relative had [condition] and now she sees a doctor once a week and has a regular appointment with a specialist doctor. The home organised this and they take her to the hospital." A GP attended weekly, and we saw that people were supported with routine appointments for oral health care and opticians.
● There was evidence of collaborative working with health and social care professionals. Health care plans were in place and records of interventions by professionals such as GP, community teams including district nurses and therapist were recorded in care plans.

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 MCA 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.

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 appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● Care plans contained evidence of people's consent to care and , if appropriate of their family members or Power Of Attorney. This is a written authorisation to allow someone to act on another's behalf.
● Mental capacity assessments were completed by nurses and where it was assessed that people did not have the capacity to consent, there was evidence of best interests decisions. Records showed that these had been made in consultation with the appropriate people such as family members including consent to care which helped to ensure that people's rights were respected.
● DoLS applications were submitted to the local authority in a timely manner; and when the appropriate circumstances arose.

Good

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. The rating for this key question has remained good.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People and relatives were positive about the care they received. Comments included, "The carers talk to my relative as if she is their friend. They use her name and have affection in their voice when speaking with her. They are respectful and kind" and "My relative seems happy and content and I think that most definitely reflects the care she receives."
- People were supported with their religious or cultural beliefs. This included in house church services for those that wished to attend.

Supporting people to express their views and be involved in making decisions about their care

- People and their relatives were involved in discussions about how they wanted to receive their care. They told us, "There is huge communication behind the scenes and the manager has an open-door policy and is proactive." Records showed and relatives told us that the home communicated any changes in people's needs.

Respecting and promoting people's privacy, dignity and independence

- People's level of independence in relation to their support needs was assessed and reviewed. This was then used to develop their care plans which included a plan of care for assessed needs for each area, the outcome, plan of care and evidence of review monthly.
- People were able to tell us of the things they were able to do for themselves. A relative said, "We think it is because the staff are allowing him his independence and he has chosen to wear what he has on. He does most things for himself. He is happy and I would know if he wasn't."

Good

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. The rating for this key question has remained good.

This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People received care that reflected their preferences. One staff member said, "All the nurses update and review the careplans- we have a resident of the day in our care system. So on the first of April, we start with room 1 and 2, we check their weight and their care plans making sure they are up to date."
- Care plans were specific to people's individual care needs. They addressed areas such as oral health, medical needs, family history and preferred activities. Where people received support with personal care their care plans defined how they preferred to receive this.
- People's care was reviewed every 6 months in consultation with them and their family members. Each person was assigned a named nurse and keyworker to allow consistency as a point of contact. They also met with people regularly.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's records included clear communication plans. Where one person required a visual aid to support their understanding their care plan detailed exactly how staff needed to use this to help the person to understand.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- A range of activities were on offer for people. The activities co-ordinator was passionate about her job and the role she played in the wellbeing of people using the service. She explained that there was a separate activities programme for people with dementia, focusing more on 1:1 activities with them. She showed us examples of the activities timetable for the home which showed a variety of activities available to people, from chess, dominoes, cinema, keep fit and yoga.
- People were asked for their opinions about the types of activities they wanted to participate in. For example, a knitting group had been introduced following people's feedback; with squares being knitted for a blanket to be sent to Great Ormond Street Hospital.
- Activities included celebrating national events such as St Patricks Day and individual celebrations such as birthdays. People were given a small gift as a present and a cake was baked for them by the kitchen team.

There were trips to the local park and BBQs during the summer.

● The activities co-ordinator told us they used people's background and experience to engage them. She gave an example of one person who used to work in an office environment. She said this person had been encouraged to get involved in preparing the 'daily sparkle', a newsletter. The person enjoyed putting the pages together and stapling them.

Improving care quality in response to complaints or concerns

● The provider, staff and relatives knew how to raise any concerns they may have. Where matters had been raised these had been dealt with in a timely manner, in line with the providers policy.

End of life care and support

● Advanced care plans were in place, these included any wishes that people had for their end of life care needs, including religious wishes, end of life plans, any wills and funeral arrangements. There was evidence that people and, where appropriate family members were involved in developing these.

Good

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.

At our last inspection we rated this key question good. The rating for this key question has remained good.

This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Some improvements were required to the home's quality assurance checks and audit systems. Whilst regular checks were in place, these were often unclear and lacking in detail as to the area that had been reviewed. For example, we found that spot checks of the home completed in different months contained the same information for each visit. Staff medicines competency assessments were also not specific enough in identifying or recording findings for each staff member. We also found that staff appraisals would have benefitted from further detail on staff development goals.
- We did find that similar issues, and the lack of detail; in relation to the general manager walk arounds had been identified by the provider during an operational directors audit. We raised this as part of our inspection feedback and the provider told us they would take action to improve governance systems.
- After the inspection the provider told us that medicines competency assessment findings would be discussed and addressed with the assessment, meaning issues were only recorded when an individual staff action plan was required. We will check on their progress with the above at our next inspection.
- The above points not withstanding, we found that the provider ensured the Care Quality Commission were informed of important events as and when they occurred.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff told us they felt supported by the registered manager. Comments included, "[The registered manager] is very good, she reached out to me. She is approachable but straight up", "The registered manager is amazing, she's ever so supportive" and "The team is brilliant, we support each other."
- People and their relatives also felt the home was well managed. Their comments included, "We have an open relationship with the manager. If we are not happy about anything we will let her know. She is there for you and has made a big difference to the home" and "[Registered manager] is approachable – I feel that she listens."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

- The provider understood the need to apologise where things went wrong, and ensured that lessons were learnt to prevent reoccurrence. Incident and accidents forms clearly detailed whether the home had considered their duty of candour responsibilities for each event that occurred.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People, their relatives and staff were consulted on their views to help drive improvements based on their feedback. This included regular staff surveys to seek their views on their employment satisfaction.

● Relatives told us, "We have had a questionnaire a few times" and "I have filled in a questionnaire type card about the service where you can say what you think about things." Records also showed that relative meetings took place and allowed for feedback to be shared and discussed with management.

Working in partnership with others

● The provider worked alongside other agencies to meet people's care needs. This included liaison with relevant healthcare professionals, reviews with funding authorities and support networks.