Leonard Cheshire Disability

Wharfedale House - Care Home Physical Disabilities

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Wharfedale House is a residential care home providing personal and nursing care to 15 people aged 18 and over at the time of the inspection. The service can support up to 18 people. The accommodation is purpose built to accommodate people with a physical disability and all rooms have en-suite bathroom facilities, there are several containing kitchen facilities.

People's experience of using this service and what we found
People told us the best thing about the service was the familiar staff who cared for them and made them feel safe. They said these staff knew them well and how they liked their care to be provided. Managers told us staff had gone above and beyond to support people through the pandemic, picking up additional shifts to ensure people had the support they required.

People told us staff always used personal protective equipment (PPE) when providing care. Staff had been trained in how to use PPE effectively. The environment was visibly clean at inspection, but there were some improvements required to evidence enhanced cleaning during the pandemic.

We found issues with documentation and record keeping. Staff did not always record their actions accurately to evidence they were following people's care plans and managing the risks to people's health and wellbeing. This was particularly evident around pressure area care, weight and support when eating and drinking. It was not always clear staff were following up on referrals to external agencies to support people's access to healthcare services to improve their health outcomes.

Recruitment practices were safe. However, the service was highly dependent on agency staff to support them. There was a lack of evidence to show the provider had assured themselves the staff had the knowledge, skills and competence to care for the people supported and they had assumed that the agency would only send staff with the required skills. People at the service spoke highly of some of the agency staff as they had been supporting them regularly. But some said they were fed up of having to tell staff how to care for them.

The provider had a good electronic medication system, but it was not being used effectively. Agency staff were not all trained to use the system, and were using paper records, which meant the records did not tally and it was not always clear people had been given their medicines as required.

People at the service, relatives and staff told us there had been inconsistent management at the service with several interim managers. They reported a lack of leadership had impacted on the quality of the service provided. More robust audits would have picked up on the issues we found and ensured improvements were made.

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

Rating at last inspection
The last rating for this service was Good (published 18 April 2018)

Why we inspected
CQC had received a number of concerns in relation to the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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 coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from Good to Requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to medicines, the management of risk and governance. Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 well-led?

Inadequate

The service was not always well-led.

Details are in our well-led findings below.

Wharfedale House - Care Home Physical Disabilities

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 Care Act 2014.

As part of CQC's response to care homes with outbreaks of coronavirus, we as part of this inspection conducted a review to ensure that the Infection Prevention and Control (IPC) practice was safe and the service was compliant with IPC measures.

Inspection team
The inspection was carried out by two inspectors and an expert by experience.

Service and service type
Wharfedale House-Care Home Disabilities is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. A new manager had been recruited in September 2020 and was in the process of registering with CQC.

Notice of inspection
This inspection was announced. Inspection activity started on 14 January 2021 and ended on 29 January 2021. We visited the home on 18 January 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We received feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and four relatives via the telephone about their experience of the care provided. We spoke with eight members of staff including the manager, quality business partner, deputy manager, team leader, two care workers, the chef, and head housekeeper. We spoke with three commissioners of the service.

We reviewed a range of records. This included four people's care records, medication records and weight records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including some policies and procedures were reviewed.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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.

Assessing risk, safety monitoring and management

● Staff had not updated risk assessments and care plans when people's needs had changed to ensure people were kept safe and protected from abuse and avoidable harm. Care plans were of variable quality with some care plans containing detailed personalised information to enable staff to care for them safely. But other care plans did not detail people's current needs.
● Staff who knew people well understood people's needs and risks associated with their care and they could tell us how they cared for people. However, we found risks were not always documented appropriately or managed to ensure people's needs were met and safety maintained. For example, People's weight had not been monitored consistently over the past year for two people. Information provided by professionals to address the concerns had not been transferred to the records kept in the kitchen or transferred into care plans.
● People's daily care records were not up to date to give an accurate reflection of the care provided. For example, food and fluid charts were not properly completed and did not accurately reflect what people had eaten or had to drink. Target amounts for fluid was not always recorded. Where it was recorded and the target not met, staff had not completed the section indicating the reason why this was not met.
● Evidence to confirm that environmental safety checks had all been carried out in line with legislation were not available such as LOLER tests for all the slings at the service and mobile hoists. Where issues had arisen from some checks, it was not clear what actions had been taken.

Risk assessment relating to the health, safety and welfare of people using the service had not be completed, reviewed regularly or included in management plans. This meant there was a risk people would not receive the care required and they could be harmed. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider acted immediately to address these issues once we raised the matter with them.

Using medicines safely

At our last inspection we recommended the provider review medicines management to make sure care staff dispose of medicines safely and appropriately. At this inspection we found that the issue found at the last inspection had been resolved but we found other issues of concern.

● Medicines were not always managed safely and consistently. Agency staff did not use the provider's

electronic medicines system and used paper medication administration records. The day staff inputted this information onto the electronic records the following day. Our review of one person's records showed that the two systems did not correlate. For example, one medicine was not signed on 16 January 2021 paper administration records but signed every day on the electronic records. This error had not been picked up prior to the inspection.
● One person's medication was not administered at evenly timed intervals as recommended for this medicine.
● The staff signature list for people's medicines was not up to date and the electronic administration record did not detail which staff had administered the medicines.
● Topical administration records did not show where cream was administered, and the records showed this was not always applied in line with the prescriber's instructions.

The provider had failed to ensure the proper and safe management of medicines which is a breach of regulation 12 (medicines) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider acted immediately to address these concerns.

Staffing and recruitment
● The provider relied heavily on agency staff to provide care at the service particularly at night. The manager told us recruiting staff to the Wetherby area was extremely difficult. Information about the skills, experience and competency of agency staff to care for people was not recorded on their profiles. The provider assured us this would be addressed immediately.
● Staff were recruited safely. Pre-employment checks were carried out to protect people from the employment of unsuitable staff.

Preventing and controlling infection
● People told us staff always wore personal protective equipment (PPE) when caring for them and we saw staff wearing PPE in line with guidance in relation to the Covid-19 pandemic. There was an ample stock of PPE at the service. PPE storage was an issue with PPE being stored on handrails on the corridor. We were advised wall mounted PPE stations were on order.
● Two housekeeping staff were at the home on the day of our inspection and the communal areas were clean. In places, the environment precluded effective cleaning. For example, in one person's room there were damaged areas of woodwork exposing a porous surface which meant it would not be effectively cleaned. Staff told us they were cleaning touch points throughout the home but there were no records to confirm this was taking place. We discussed these issues with the management team who agreed to look into rectifying these concerns.
● Cleaning staff were using the right products for the tasks but diluting them incorrectly and not to the manufacturer's instructions recorded on the products. We have advised the manager to seek guidance in relation to this as it is crucial for the effectiveness of a product to be diluted as recommended.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe with staff that supported them particularly permanent staff but also the regular agency care staff. They said they had concerns about the behaviour of another person at the service who made them feel unsafe at times and they said they had reported this to their care staff.
● Staff had received safeguarding training and were clear about the processes they would follow if they needed to report any safeguarding concerns.

Learning lessons when things go wrong

● Accidents and incidents, such as near misses were not always recorded to allow for a detailed analysis. Therefore, any themes or trends were not identified to mitigate risk and ensure lessons learned. For example, where a person had choked.

Inadequate

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Leadership was weak and inconsistent. The service had been managed by four different managers over the past year with short periods without a manager. This instability during a pandemic had affected the monitoring of the quality of the service. The current manager was new in post and had a period of absence. Information we asked staff for during the inspection, which should have been readily available was not easily accessible to us without a delay.
- People and their relatives told us the inconsistency of managers over recent times had impacted on the quality of the service. One relative said, "It needs a permanent manager who gets to know the residents." Other relatives and people told us the large turnover of staff had a negative impact on the service.

Continuous learning and improving care

- A variety of audits were carried out at the service. They had not picked up the issues we found at inspection which meant concerns were not escalated. For example, people's weights had not been consistently monitored and there was no system in place to allow a management oversight of the issue. This was addressed as soon as we raised the issue.
- Systems in place to monitor the service were not used effectively to drive improvements. For example, the provider had a good electronic medication system, but as it was not used by all staff administering medicines it was ineffective and errors were happening. There was a lack of oversight to identify the risks this posed to the safety of the people at the service. The management team agreed to investigate this immediately.
- We found care plan audits had taken place and the audit tool was left in the person's care plan. These highlighted the actions required to improve the care file but there were no dates to detail when these actions were to be completed and there was no review to check these actions had been completed. As a result, this audit had not effectively driven the desired improvement.
- Agency staff were covering night shifts and supported people with complex health and social care needs. There was no recorded evidence to demonstrate the provider had checked their competencies in these areas and the information provided by the agency did not confirm they had these skills. The manager agreed to address this as a matter of urgency.
- There were gaps in people's daily records, and it was unclear whether care had been provided.

The systems in place to monitor and improve the quality of the service were not effective. The service had

failed to keep an accurate, complete and contemporaneous record of the care provided to each service user. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● We had received concerns prior to the inspection in relation to how the service managed complaints. The provider is looking into this matter. We were shown details about recent complaints and how the service responded to these. We noted at inspection that not all informal concerns people had raised had been recorded to allow the provider to respond and take action appropriately.

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

● People and their relatives were very positive about the staff at the service. One relative said, "I feel the staff are actual carers. They do actually care for my (relative). The care is very, very good." Another said, "The people on the ground are exemplary."

● The management team also praised the staff and how they had gone above and beyond to support people during the pandemic.

● Staff morale had been affected by the turnover of managers at the service plus a difficult 12 months during the pandemic. Staff wanted the service improved and enjoyed working with the people at the service.

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

● Several people we spoke with told us management at the service were not very visible. One said, "No. I don't see the manager regularly." When asked how well-led the service was one replied, "It's had its good times. Can't blame the manager – not here long enough."

● People told us they had not recently completed any surveys, or questionnaires, but they did say the manager had recently set up meetings going forwards with people, which they welcomed.

● Relatives told us they were kept informed of issues or general welfare of their loved ones. One said, "We can phone any time. They're always available."

Working in partnership with others

● The provider engaged with healthcare professionals. We found that advice was sought when people's needs changed although there were some exceptions to this noted at inspection. The correspondence was not always formally documented in people's plans of care and staff were reliant on their memory for the detail of the interventions.

● Where people were commissioned from out of county there was no information in their care files to confirm who and when a review of their care needs had taken place to confirm the placement was still meeting people's needs and outcomes.

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 12 HSCA RA Regulations 2014 Safe care and treatment 12(2)(g)The provider had failed to ensure the proper and safe management of medicines 12(2)(a)(b) Due to the lack of accurate records showing how risks were assessed and mitigated, there was a risk people would not receive the care required and they could be harmed

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17(2)(a) The systems in place to monitor and improve the quality of the service were not effective. 17(2)(c) The systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others were not robust. 17(2)(c) An accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided was not maintained.

The enforcement action we took:

Warning notice