Shaw Healthcare (Group) Limited

Wellesley Road Care Home

Inspection report

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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**

Overall summary

This inspection took place on 28 and 30 July 2015 and was unannounced. This was the first inspection of this service since it was registered with the Care Quality Commission in June 2015.

We undertook the inspection at this time because we received concerning information regarding the home.

Wellesley Road Care Home provides accommodation, nursing and personal care for up to 60 older people most of whom have dementia. The home has 60 bedrooms over three floors and six units, each containing 10 bedrooms. The home has been newly built as part of a relocation of two existing care homes for older people, run by Camden Council, which have now closed. People were moved from the two Camden Council run homes to Wellesley Road Care Home in June 2015.

The home had a registered manager who is also registered for another 60 bedded care home located nearby run by the same provider. The registered manager spends most of her time at the other care home and the provider has employed a manager who is working full time at Wellesley Road and has applied to be registered for this home.

Summary of findings

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 and associated Regulations about how the service is run.

People told us they felt safe and comfortable with the staff who supported them.

We observed kind and positive interactions between staff and people using the service. However, we observed that staff were very busy throughout the two days of the inspection. This meant that staff had little time to meet the more holistic needs of people at the home as most of staff time was taken up on trying to meet people's basic personal care tasks. People using the service, their relatives and staff working at the home, told us they had concerns about staffing levels.

We saw that staff sickness levels were high and presented a challenge for the management of the home. This had led to a high use of agency staff as well as moving existing staff around the units to provide enough cover. This had a negative effect on the continuity of care that some people received because staff were not always familiar with the care needs of people they were supporting.

Procedures in relation to the management of medicines needed to be reviewed as this was putting people at risk of harm due to possible medicine errors.

Staff understood the principles of the Mental Capacity Act 2005 (MCA) and told us they would presume a person could make their own decisions about their care and treatment.

We met with the local doctor who was visiting the home on the day of our inspection. They were positive about the staff at the home.

Care planning was only recently been implemented. Care planning remained underway but had not yet been completed in respect of all people who use the service. People's individual care needs were not always known by staff due to staff shortages and subsequent deployment on different floors at the home.

Food looked and smelt appetising and the cook was aware of any special diets people required either as a result of a clinical need or a cultural preference.

People told us they liked the staff who supported them and that staff listened to them and respected their choices and decisions.

People's privacy was not always being respected and there were problems with ensuring that people's confidential information was kept safe.

The culture within the home needed improvement. There was a lack of trust between staff and management. Communication between management and staff was not always effective and we saw examples where essential information was not communicated between staff and management. Staff understood the principles of how to "whistle-blow", but said they did not feel confident in raising their concerns with management.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to the management of medicines and good governance. You can see what action we told the provider to take at the back of the full version of the report.

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. This was because systems to ensure medicines were handled and administered safely were not effective.

Some relatives and staff had concerns about staffing levels within the home.

Requires improvement

Is the service effective?

The service was not always effective. Staff were not always aware of the appropriate lines of reporting within the home so some information that was being recorded was not always being passed on to senior staff.

People were positive about the staff and felt they had the knowledge and skills necessary to support them properly.

Staff understood the principles of the MCA and told us they would always presume a person could make their own decisions about their care and treatment.

People told us they enjoyed the food which looked and smelt appetising. The cook was aware of any special diets people required either as a result of a clinical need or a cultural preference.

Requires improvement

Is the service caring?

The service was caring. However there were instances where people's personal records were not being kept secure or in line with data protection requirements.

People told us the staff treated them with compassion and kindness.

We observed staff treating people with respect and as individuals with different needs and preferences.

Staff understood that people's diversity was important and something that needed to be upheld and valued.

Requires improvement

Is the service responsive?

The service was not always responsive. Although everyone had written information about their care needs, this information was often missing key pieces of information and sometimes difficult for staff to access.

Relatives told us they were not always confident that their concerns or complaints would be listened to or addressed by the management of the home.

We saw that when people using the service were able to be engaged in activities this had a positive effect on their well-being.

Requires improvement

Summary of findings

Is the service well-led?

The service was not always well-led. Communication between staff and management was not always effective and there was a lack of trust. The culture of the home required improvement.

The service had a number of quality monitoring systems including yearly surveys for people using the service, their relatives and other stakeholders. As the service was very new some of these systems had not yet been put in place.

Requires improvement

Wellesley Road Care Home

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 checked 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 unannounced inspection took place on 28 and 30 July 2015 and was undertaken by two inspectors and a specialist advisor with particular knowledge, qualifications and experience of pressure ulcer management. An Expert by Experience also attended the first day of 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.

Before our inspection we reviewed information we have about the provider, including notifications of any safeguarding concerns or incidents affecting the safety and well-being of people.

We met with 25 people who used the service, however, due to people's cognitive impairments, some of the conversations with people were limited and we were only able to say hello and ask how they were feeling. Because of this we spent time observing interactions between people and the staff who were supporting them.

We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people was having a positive effect on their well-being.

We spoke in more detail with sixteen people who were more able to give us their views. We spoke with eight relatives, both during the inspection and after the inspection, over the phone.

We spoke with 12 care staff and two nursing staff both during the inspection and after the inspection over the phone.

We spoke with the manager employed by the organisation to run the home, the clinical lead for the organisation, four quality managers, including the head of quality for Shaw Healthcare, the project manager and the registered manager.

We spoke with three social care professionals and six healthcare professionals who had regular contact with the home.

We looked at 17 people's care records and other documents relating to their care including risk assessments and medicine records. We looked at other records held at the home including health and safety documents, staff rotas, menus and seven staffing files.

Requires improvement

Is the service safe?

Our findings

We observed kind and positive interactions between staff and people using the service. However, we observed that staff were very busy throughout the two days of the inspection This meant that staff had little time to meet the more holistic needs of people at the home as most of staff time was taken up on trying to meet people's basic personal care tasks.

A number of relatives we spoke with were concerned about staffing levels and some relatives told us they were so worried about the lack of staff that they visited the home on a regular basis to ensure that their relatives had enough exercise as well as enough to eat and drink. One relative commented, "I have trouble getting into the building, I waited for 30 minutes one weekend just to get in." Another relative told us, "there is not enough staff and I don't feel there is enough stimulation. It feels like staff are too busy to attend to personal and individual needs." Another relative commented, "We never see enough people. In the mornings there are quite a lot of staff but in the evenings there are not." Some people using the service told us the staff did not have enough time to be with them. One person told us, "They are always busy." Another person commented, "I feel isolated." However, one person we spoke with told us, "They look after us very well. Obviously, I'd rather be at home. People are always about."

Social care professionals told us they had identified "pinch points" during the shifts where staff struggled to meet people's needs particularly in the morning. They told us they sometimes helped out with breakfast as staff were very busy getting people up and attending to their personal care tasks.

Each unit had two care staff. However, two staff were needed to provide personal care to those people with higher dependency care needs in their rooms. Team leaders were responsible for two units and we saw that they were often outside the unit attending to medicine issues, answering the unit phone or writing up care notes.

Each unit had a reception area. On four of the six units this was situated outside of the unit and contained people's care records and the unit telephone. We saw that staff using the telephone or writing reports were outside the units and were not near the people they were required to support.

Staff told us that staffing levels were insufficient to meet the needs of the people at the home. Staff told us that the management were not aware of people's high dependency needs and the amount of time it took to undertake care tasks such as transferring people from their bed to a chair, repositioning people who were in bed and the amount of support people needed with eating and drinking.

We asked the home manager and project manager how staffing levels were assessed. We were told that this was worked out by looking at people's dependency levels. However, when we requested to see how people's dependency levels were calculated, we were told that this was not yet taking place on a regular basis. We were informed by the management of the home that a "48 hour diary" would be carried out for each person using the service so their level of dependency could be assessed but acknowledged that this assessment had yet to be implemented.

We saw that staff sickness was high and presented a challenge for the management of the home. This had led to a high use of agency staff as well as moving existing staff around the units to provide enough cover.

On the second day of the inspection seven of the 12 staff on duty were from an agency. These agency staff were working very hard with the existing staff to meet people's needs. But one staff member told us, "We want to find out more about them but we just don't have the time. We are always rushing."

Some team leaders we spoke with were unsure if they were authorised to call agency staff if staff phoned in sick during the evening shift. This meant that they waited until the morning so the management called the agency then and there was a shortage of staff until the agency worker arrived.

When people had moved into this newly built home from the two Camden run homes they had arrived with their key worker who knew their care needs. However, some staff and relatives told us that due to staffing shortages, staff had been deployed on units away from the people they knew. This had led to staff not always knowing about the needs of the people they were now supporting. We were told that three people had stayed in bed for approximately two weeks. Although these three people were no longer staying in bed all the time, we were not given a satisfactory explanation why this had occurred. Some staff told us they

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Is the service safe?

thought it may have been on the advice of their GP or district nurse but could not be sure. Current research suggests that excessive bed rest can lead to atrophy and a loss of muscle strength among other complications including pressure ulcers.

We were not provided with a satisfactory explanation of why this had occurred. As a result, people were potentially put at serious risk of harm. This issue was reported to the local authority safeguarding team.

Social care professionals told us they had completed a needs assessment of everyone coming into the home. We saw these assessments which included basic risk assessments. Key workers were also aware of people's risks.

Some staff said this situation had improved over time and we saw that the organisations quality team were busy completing everyone's care plans and risk assessments.

The newly developed care plans we reviewed included relevant risk assessments, such as the Malnutrition Universal Screening Tool (MUST), used to assess people with a history of weight loss or poor appetite. There were also risk assessments in relation to falls and continence management. Where a risk had been identified the management had looked at ways to reduce the risk and recorded any required actions or suggestions.

We checked with staff if they were aware of these actions and they were able to tell us how they reduced risks to people's safety and welfare.

We saw that risk assessments and checks regarding the safety and security of the premises were up to date and being reviewed. These included the fire risk assessment, monitoring water temperatures to reduce the risk of scalding and checks to reduce the spread of water borne infections such as Legionella.

We checked staff files to see if the service was following robust recruitment procedures to make sure that only suitable staff were employed at the home. Recruitment files contained the necessary documentation including references, criminal record checks and information about the experience and skills of the individual.

Prescribed medicines were dispensed by the local pharmacist. Medicines were kept in individual boxes and containers were clearly labelled with the name of the person and the date dispensed.

We checked the Medicine Administration Record (MAR) charts and found the staff had generally completed and signed them correctly however there were a number of gaps in recording. For example, we saw gaps in recording of all eight people's records on one unit. The team leader told us, as there had been a number of medication errors and two subsequent safeguarding referrals, team leaders were instructed to undertake a medicine audit after each shift. This meant counting all the tablets in all the boxes and so team leaders were away for their units while they were auditing. One team leader told us, "It takes a long time." These audits were time consuming and not always effective as we found gaps in the administration records. We found no evidence during our inspection of medicine errors however; the management had identified two errors and had referred these matters to the local safeguarding team.

This was in breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of the inspection we observed an agency team leader administering medicines. We asked the manager if agency staff had a local induction or shadowed a permanent member of staff before being able to administer medicines. We were informed that they relied on the agency to make sure agency staff had undertaken medicine training and were safe to do this.

We discussed this with the management of the home who agreed to review the systems and processes in relation to medicines in order to make the process safer and less time consuming.

Records showed that five full time staff were able to administer medicines as well as any agency staff deployed. Records showed that only two of these full time staff had received a competency assessment to ensure they were able to safely carry out this task. We were later informed by the provider that five staff had undertaken competency assessments.

People told us they felt safe and comfortable with the staff who supported them.

One person, referring to the staff, told us, "They are very good." Another person commented, "They do very well."

Staff we spoke with could explain how they would recognise and report abuse. They told us, and records

Requires improvement

Is the service safe?

confirmed, that they had received up to date training in safeguarding adults. Staff were aware that they could report any concerns to outside organisations such as the police, the Care Quality Commission or the local authority.

Requires improvement

Is the service effective?

Our findings

We spoke with the local GP who is contracted to visit the home every week. He told us that the staff were prompt in following any medical advice or interventions he suggested. The community nurse told us they had no particular concerns about the service.

Four relatives told us they were unhappy because they felt it took a long time for staff to arrange outside healthcare appointments. They told us that they were worried about their relative's nails as they were getting long. We met two visiting podiatrists who were visiting the home on the day of our inspection.

Although we saw that staff were recording any issues or concerns they had with people when providing personal care, this was not always being reported to senior staff. Staff were completing body maps of anyone where a skin problem or similar concern had been noticed by them. However, senior staff were not notified. We showed these records to the quality team who said they would make sure staff were following correct reporting procedures and that they alerted the management when concerns were noted.

People who used the service were positive about the staff. One person we spoke with told us, "They are kind and agreeable."

Staff told us that before moving to the new home they had undertaken training from their previous employer. One staff member told us, "Before we came here we did a lot of training." Staff told us were provided a good level of training in the areas they needed in order to support people effectively.

Some staff told us they had undertaken training in pressure area care some months ago. The clinical lead for the organisation told us that, as a result of our discussions with them about care planning and risk assessments, they had identified a number of further staff training needs. They told us they would be setting up a number of training workshops including pressure care management, nutritional needs and risk assessments.

Staff who were transferred from the two care homes were offered a four day induction at Wellesley Road's sister home. This was not compulsory and we were told by the management that many of the staff did not attend. We were told that staff had a local induction at Wellesley Road regarding health and safety procedures.

Staff understood the principles of the Mental Capacity Act (MCA 2005) and told us they would always presume a person could make their own decisions about their care and treatment. They told us that if the person could not make certain decisions then they would have to think about what was in that person's "best interests" which would involve asking people close to the person as well as other professionals.

One staff member told us, "It is about the client, if that individual is able to make their own judgement. [They] would need to be assessed and deemed not able to make a decision."

Deprivations of Liberty Safeguards (DoLS) were put in place where it was necessary to restrict a person's access to areas within the home or stop them from leaving the home because they would not be safe on their own. The two local authority social workers, who were currently working at the home, told us that everyone had been assessed under the MCA 2005 before they moved into this home and that relevant DoLS were in place where required. Records we saw confirmed this.

We observed staff asking people for permission before carrying out any required tasks for them. We noted staff waited for the person's consent before they went ahead. People told us that the staff did not do anything they did not want them to do.

We saw risk assessments for people who had a loss of appetite or those prone to choking or with swallowing difficulties. Where people were known to have a poor appetite or another nutritional risk factor, a daily food and fluid intake monitoring chart was in place. We saw the charts in use had been completed after each shift to reflect people's daily food and fluid intake. However, these records were completed retrospectively by staff at the end of their shift and we were concerned that staff may not remember exactly how much people had ate or drank. Some of the fluid intake charts suggested a low fluid intake. Staff told us that it was time consuming to fill out these charts so the low amount of fluid intake may have been a recording issue.

Requires improvement

Is the service effective?

We discussed this with the clinical lead for the organisation who agreed to undertake some training for staff so they better understood the purpose of this monitoring.

We recommend that the service seek advice and guidance from a reputable source, about the appropriate and timely recording of the food and fluid intake of people using the service where this is required.

We saw that, where a possible eating problem had been identified, the management had referred people to the speech and language therapist**.** Their advice had been reflected in the person's care records and appropriate risk assessments had been done on their healthcare and personal safety. We spoke with the speech and language therapist who told us that she felt that referrals were appropriate and the staff referred people when needed. We also witnessed a speech and language assessment when conducting a short observational framework (SOFI) at lunchtime.

Care records showed people's weight had been recorded at the time of admission and people's weight was being monitored.

We saw there was a choice of two lunchtime meals as well as a vegetarian alternative. People were happy with the food provided at the home. One person commented, "The food is good. There's nothing wrong with the food at all."

Food looked and smelt appetising and the chef was aware of any special diets people required either as a result of a clinical need or a cultural preference.

We observed lunchtime on five separate units in the home. Everyone was offered a choice of meals and most staff were aware of people's food preferences. Staff were busy but we saw they were able to sit with people who needed some support with their meal.

Requires improvement

Is the service caring?

Our findings

People told us they liked the staff who supported them and that they were treated with warmth and kindness. One person told us, "The staff are nice. Everyone is absolutely wonderful."

Staff gave us examples of how they maintained people's privacy in relation to the provision of personal care and information sharing. However, we found that people's privacy was not always being maintained or respected.

We saw that staff were not always keeping confidential information about people private or safe. We noted on four of the units that GP notes and care plans were not locked away and were left unattended.

Staff told us they enjoyed supporting people and we observed staff treating people with respect and as individuals with different needs and preferences. Staff understood that people's diversity was important and something that needed to be upheld and valued. They gave us examples of how they respected peoples' diverse needs. People told us that staff listened to them respected their choices and decisions.

Some relatives we spoke with were concerned about the care people received which was mainly based on a lack of staff. One relative commented, "The building is beautiful. The care is not and I would move [my relative] out if I could."

Throughout the two days of the inspection we observed both permanent and agency staff supporting people with kindness and compassion. We saw many examples of well-being displayed by people using the service. People were engaging well with staff and with us and each other.

People were chatting with staff and laughing and joking with them and us. Where people displayed signs of confusion or distress, staff were both gentle and reassuring with them.

We saw that people using the service and their relatives were beginning to become more involved in their care planning. We saw that the quality assurance team were talking to people about how they wanted their care to be delivered. This was being recorded in people's new care plans as well as discussions about possible risks to people's safety.

Requires improvement

Is the service responsive?

Our findings

Although everyone had written information about their care needs, this information was often missing key pieces of information and sometimes difficult for staff to access. The majority of staff we spoke with told us they did not have enough time to read about people's care needs and had to rely on verbal information from staff who knew the person better or, if they could, they would ask the person themselves.

A relative told us about their experience on the first day of their loved one's admission. They said, "On the day of arrival, there was no greeting from the staff or explanation of who they were. I was not given any contact details for the home despite asking." We were informed by the provider after the inspection that all relatives were provided with a Service User Guide for Wellesley Road by Camden Council in advance of the move.

We saw that new care plans were being developed by the quality team. The completed care plans we saw were detailed and included a detailed account of all aspects of people's care, including personal and medical history, likes and dislikes, recent care and treatment and the involvement of family members.

Staff told us that, due to the issues with staffing, activities were a challenge for them. Relatives told us they were concerned about the "lack of stimulation". Relatives we spoke with commented, "The home is lacking in activities, [my relative] had been very active at [the previous home] now she's rolled up in a blanket on her bed. She used to be a very active person and although the facilities are great there is no stimulation."

The manager told us that they were in the process of recruiting two activity coordinators and we saw a number of activities taking place at the home on both days of the inspection.

We met with the music therapist on the first day of the inspection. She worked with people individually and in groups. People were enjoying the sessions and we heard a lot of singing coming from people's rooms. It was positive to hear people singing to us well after the music therapist had left.

The management told us that no formal complaints had been received by the service however, they were aware that several complaints about the home had been made to the local authority.

Relatives told us they were not always confident that their concerns or complaints would be listened to or addressed by the management of the home.

A relative told us, "I don't know who to speak to." Another relative commented, "It's only been open a month, there are teething problems. I have had problems with them [and] getting information. These have been sorted out and I have no issues with them now."

Requires improvement

Is the service well-led?

Our findings

There was a lack of trust between staff and management. Staff did not always feel confident in raising concerns with management. Communication between management and staff was not always effective and we saw examples where essential information was not communicated between staff and management.

Staff understood the principles of how to "whistle-blow", but said they did not feel confident in raising their concerns with management. The culture within the home needed improvement.

We were informed by the management that meetings with people using the service and their relatives had been planned for the coming month.

Although the management told us that people at the home all had a key worker, the majority of staff we spoke with were not always sure who they were key worker for and this information was not consistently recorded in people's care records.

When the move was being planned from the Camden run homes to this new home, staff had been invited to meet the management of Shaw Healthcare and so get an understanding of the visions and values of the organisation. However, we were told that a number of staff had not attended these planning days.

Staff told us that there had been one staff meeting since the home opened.

Personal information about people was not being held securely and was not always being completed in sufficient detail. Some staff we spoke with were not aware of the management and reporting structure of the organisation. For example, all staff understood that they must record all accidents and incidents but some staff did not know who they should report accidents to. This had led to accidents being recorded but not always reported so any meaningful analysis could not be undertaken by the management.

This was in breach of Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a number of quality monitoring systems including yearly surveys for people using the service, their relatives and other stakeholders. As the service was very new most of these systems had not yet been put in place. There were daily, weekly, monthly and quarterly health and safety checklists. The daily, weekly and monthly checklists had been completed and signed. At the time of our inspection the home had not been open long enough to complete quarterly checklists.

A fire safety policy and procedure were in place. The fire risk assessment was clear and accessible. Fire marshals had not yet been named as they had not received the required training. We viewed ten people's personal evacuation plans and saw these had been completed.

The management acknowledged that there were problems with the relationship and communication between the management and the staff who had moved from the other homes. We were informed that they would be setting up a one to one meeting with individual staff in order to get their views about the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had failed to ensure the consistent, proper and safe management of medicines at the service. This was because systems for monitoring and auditing medicines were not always effective. **Regulation 12(2)(g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had failed to maintain securely an accurate, complete and contemporaneous record in respect of each person using the service. **Regulation 17 (2) (c)**