Abe Health Care Ltd

Wathwood Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 16 and 17 February 2016 and was unannounced. This is the first inspection of the service since its registration with the care Quality Commission on 31 December 2015.

Wathwood Lodge is a care home providing accommodation for up to five people. It is situated close to Wath Upon Dearne town centre and has limited restricted parking. It provides accommodation on both the ground and first floor and has gardens to the front and rear of the building.

The service has a registered manager. 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.

We carried out this inspection because we received information of concern and we wanted to check if the one person receiving the service was safe and received appropriate care that met their needs

We found procedures in relation to recruitment and retention of staff were not sufficiently robust which may mean that people who used the service may receive care from staff that were not suitable.

We found staff had received some training however staff told us that they had not received practical moving and handling training. Most of the training was video based. We could not confirm the quality of the training would enable staff to deliver safe care and treatment.

We found people were put at risk from harm due to insufficient staffing levels which had impacted on their care and safety.

We found records to ensure people received appropriate safe care were inadequate. There were no assessments of the persons care, health and welfare needs and no care plans to direct staff how to safely deliver care and meet their needs. We also found there were no risk assessments in place to ensure any risks to the person in relation to their care, health and welfare could be identified so these could be manage and mitigated.

The provider was aware of the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). We found the person receiving care at the time of the inspection had capacity to make informed decisions about their care and treatment.

We found insufficient evidence that the service was meeting the person's nutritional needs. There were very little food at the service and there was no evidence that fresh cooked meals were being provided.

The service had medication procedures in place however we found records to be inaccurate and medication

was not stored securely.

We observed good interactions between staff and people who used the service. People were happy to discuss the day's events and they told us staff were kind and caring.

There were eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking action against the provider and will report on this when completed.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff knew how to recognise and respond to abuse correctly. They had an understanding of the procedures in place to safeguard people from abuse.

There was not sufficient staff with the right skills and competencies to deliver care safely

There was no care plan in place to enable staff to deliver care safely

Recruitment systems were not robust.

Medicines were not stored or recorded safely.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received adequate training to ensure they had the skills and competencies to safely deliver care to people who used the service.

There was insufficient evidence that people's nutritional needs could be met.

The design and equipment at the service did not ensure people could safely receive the care they needed, when they needed it.

Is the service caring?

Inadequate

The service was not caring.

People told us they were happy with the support they received. We saw staff had a warm rapport with the people they cared for. However, due to inadequate staffing levels people had to wait significant periods of time for their care needs to be met which impacted on their dignity and wellbeing.

Is the service responsive?

Inadequate

The service was not responsive.

We found that peoples' needs were not thoroughly assessed prior to them staying at the service.

Records did not describe the care and support staff needed to provide to meet people's needs.

The service had a complaints procedure that was accessible to people who used the service and their relatives. People told us they had no reason to complain as the service was good.

Is the service well-led?

Inadequate

The service was not well led.

The registered provider did not ensure there were safe systems in place to ensure the safety and welfare of people who used the service.

Accidents and incidents were not monitored effectively to ensure risks could be identified and mitigated to prevent reoccurrence.

Wathwood Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 16 and 17 February 2016 and was unannounced. The inspection was undertaken by an adult social care inspector. At the time of the visit there was one person using the service. We spoke with the person. We also spoke with the relative of one person who used the service. We spoke with three care workers and the acting manager of the service. We also observed how staff interacted and gave support to the person.

We brought forward this inspection because we received information of concern that the person using the service was not receiving safe care and treatment. We looked at documentation relating to one person who has used the service, staff and the management of the service. We also looked at the systems used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Following this inspection we made a safeguarding referral to the local authority. We also spoke with a district nurse, commissioners and contract monitoring officer, and they have shared similar concerns about the service.

Inadequate

Is the service safe?

Our findings

We spoke with one person who used the service and they told us they were well looked after by the staff at the home.

We looked at the documentation available to us regarding the care needs of one person. We found there was no care plan to direct staff how to deliver care safely. We found information from a visiting district nurse which stated that the person should have complete bed rest. However the person was sat in a reclining chair in the lounge during this inspection.

The daily records told us that the person had fallen out of a double bed and the night staff had assisted to get the person back into bed. There was no evidence that an accident report had been completed or that correct techniques were used to assist the person from the floor.

We found people were put at risk from harm due to insufficient staffing levels and we saw there was only one staff member on duty for significant periods of time. We saw on daily notes that the persons choice was limited with regard the time they wished to go to bed. This was because the information on the care file for the person stated that two staff were needed to transfer the person safely. While we observed the person they were falling to sleep and told us they were tired and wanted to go to bed. This was at 7pm. The staff member told us that there would not be able to manage to move the person safely and had concerns that the night staff was not due to arrive until 9pm. We contacted the acting manager who attended the home. They said that the person could be assisted to bed with one member of staff. This was contrary to information we saw in the persons care file and staff we spoke with did not feel the person could be safely assisted to mobilise with one staff.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We checked and was told that the service has no moving and handling equipment this meant the person was at significant risk from harm when they had fallen during their stay. There was no risk assessment to manage this risk.

We asked the acting manager if the person had a personal evacuation to use in case of an emergency at the service. We were told there was no plan was in place for the person. The lack of an emergency plan and only one staff member being on duty put the person at significant risk should there be an emergency which required them to be evacuated.

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

Staff had access to policies and procedures about keeping people safe from abuse and reporting any incidents appropriately. The home manager told us they would report any allegations of abuse to the relevant agencies such as the local authority safeguarding and the Police. The staff we spoke with demonstrated a good knowledge of safeguarding people and could identify the types and signs of abuse, as well as knowing what to do if they had any concerns of this kind. We found records which gave us concerns about the care and treatment of the person who used the service.
Following the inspection we contacted the local authority safeguarding team to make them aware of our concerns.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw there was a medication policy in place which looked at all aspects of the safe handling, storing and administration of medicines. However when we looked at the records of medication administered we found they were not being recorded accurately. We found staff were recording the administration of medication in the daily notes as a medication administration record (MAR) was not available at the time of the persons admission. This was not rectified for three days. We found one person's prescribed medication was being administered incorrectly. The medication was stored in the fridge in the kitchen and stated that the medication should be stored between 2 and 8 degrees. There was no system to record the temperature of the fridge which meant it may not be stored correctly. We found that other medications were being stored in an unlocked cupboard in the kitchen. This meant they were not safely stored.

We asked staff if they had received training in the safe management of medications. They told us that the acting manager had given instruction in this subject. This meant staff may not be adequately trained to undertake this task therefore putting the person at risk of harm.

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

We checked five staff files and found appropriate checks had not been undertaken before staff began working for the service. Four files did not contain two references and these included references from previous employers. We were given the Disclosure and Barring Service (DBS) check numbers for four staff however one staff members DBS check could not be located. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. We checked with the previous employer for one of the staff members who confirmed to us that they had not been asked to provide a reference for the person.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service effective?

Our findings

We looked at the records for the person who used the service and found no evidence that the person had been involved in decisions about their care. There was no evidence of records that provided evidence that the person had consented to their care, however the person told us that they had received good care but was ready to go back home. Relatives we spoke with told us that they thought the care was good and the person seemed better than before they were admitted to Wathwood Lodge.
This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff were aware of the Mental Capacity Act and the Deprivation of Liberty Safeguards. This legislation is used to protect people who might not be able to make informed decisions on their own. The staff we spoke with told us that the acting manager had delivered the training and had used one of the modules from the care certificate to give examples of depriving someone of their liberty.

We looked at the training records and found staff had received some instruction in areas of fire safety, nutrition and food and drink, safeguarding, infection control and moving and handling. The acting manager told us that she had delivered some of the training and that she was qualified to do this. We asked but were not shown any certificates to confirm this. Staff we spoke with told us they had not received practical training in moving and handling and they expressed that they were worried about moving the person receiving the service without that element of training. Staff told us most of the training involved watching training videos. We saw no assessments or evaluation of the training provided had been undertaken with staff to ensure the training had been appropriate and staff were confident and competent. There was no evidence of supervisions taking place. There were no certificates of attendance on staff files we looked at.

We found there was very little information on the records we looked at to confirm the nutritional needs of the person who used the service. We looked in the kitchen to assess if sufficient food was available. We found the fridge and freezer had very little provisions. In the freezer there were only some frozen peas and the fridge contained three ready meals, milk and some spread. The pantry had a few tins of soup, biscuits,

bread and some cereal. There was no evidence of fresh foods except for two over ripe bananas. We spoke with the person who used the service and they told us their appetite was poor and confirmed that they had eaten some cereals. No nutritional assessment had been carried out or advice sought from a healthcare professional to ensure this diet was suitable to meet their nutritional needs.

This was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

The person and their relative that we spoke with told us that the care was good and the staff were caring and kind. We observed staff interacting with people who used the service in a kind and compassionate manner. We saw staff were respectful and maintained the person's dignity.

The staff we spoke with told us that they had raised concerns with the acting manager about the care of the person who used the service. They told us that they were worried about meeting the person's needs in a timely way when they were on duty on their own.

We looked at the daily records and found an incident where the person had requested to go to the toilet but due to their poor mobility the staff member was unable to meet their needs. The person had to wait for three hours before assistance could be offered. The staff member told us that this had caused great distress to the person. We also found this person was sitting in a reclining chair and told us they wanted to go to bed but staff had to wait a further two hours for the next member of staff to come on duty to assist them to bed.

We found suitable moving and handling equipment was not available at the service. The person who used the service was unable to stand independently from the sofa in which they were sat. The acting manager told us that they had purchased a rise and recliner for the person to assist with standing. We saw from the daily records that the chair arrived seven days after the person had been admitted into the service.

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

Inadequate

Is the service responsive?

Our findings

We found no evidence that the person who used the service had been involved in their care and treatment. There was no care plan to enable staff to deliver care safely. We spoke with the district nurse who had visited the person at the service. They raised concerns about the care and felt that care was not person centred. They told us the lack of equipment meant the person would be better cared for in bed for their and staff's safety. We spoke with the acting manager of the service and they told us that a riser/recliner chair meant the person could be moved safely. They told us this had been confirmed by the Physiotherapist. We found no evidence to support this decision.

We saw that the person had fallen out of bed during the second night of their staff. The service had responded to this by obtaining a more appropriate bed. However this equipment should have been provided before the person was admitted to the service but no pre-admission assessment of their needs had been carried out which. From the records the bed had arrived two days into the persons stay at the home. The acting manager told us that the person was known to the service as they also provided domiciliary care to the person.

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

There was comprehensive complaints policy and procedure; this was explained to everyone who received a service. The acting manager told us that they had not received any complaint since the service opened in early February. People we spoke with did not raise any complaints or concerns about the care and support they received. The relatives we spoke with told us they had no concerns but would discuss things with the staff or the provider if they needed to raise any issues.

Inadequate

Is the service well-led?

Our findings

The service was led by a manager who has been registered with the Care Quality Commission at this location since February 2016. The provider had appointed a home manager to oversee the day to day running of the service.

We found the provider had not taken into consideration the equipment needed to support the person who used the service prior to their admission. There was no care plan to help staff to deliver care safely to the person and staff had not completed the necessary accident report when a fall occurred in the service.

The registered manager had not ensured all of the necessary checks before a staff commenced in employment. Staff had not received adequate training in the safe management and storage of medication which meant the person was put at risk of harm.

There were no risk assessments to ensure people who used the service received safe care and treatment. This included falls risk and personal evacuation plans which puts people at significant risk of harm.

The registered manager had failed to recognise that staffing levels were insufficient which put the person who used the service at significant risk of harm. This had caused great to distress to both the person who used the service and staff members.

We were unable to assess if the registered provider had any quality monitoring systems in place.

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

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 9 HSCA RA Regulations 2014 Person-centred care The provider did not take reasonable practicable steps to make sure that people who use the service received person-centred care and treatment that was appropriate, meets their needs and reflects their personal preferences. Regulation 9 (1)(a)(b)(c) (3)(a)(b)(c)(d)

The enforcement action we took:

NOD to cancel RA

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to demonstrate how consent to care and treatment was gained for people who used the service. Regulation 11 (1)

The enforcement action we took:

NOD to cancel RA

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 provide care and treatment that was safe and met people's needs. Risks had not been considered to keep people safe from harm. Medication procedures were not safe and medication was not stored securely. Equipment to move people safely was not available therefore put people at significant risk of harm. Regulation 12 (1)(2)(a)-(g)

The enforcement action we took:

NOD to cancel RA

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to safeguard people who used the service from suffering any form of abuse or improper treatment while receiving care and treatment.

The enforcement action we took:

NOD to cancel RA

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to demonstrate how they would ensure they met the nutritional needs of people who used the service. Regulation 14 (1)(2)(4)(a)

The enforcement action we took:

NOD to cancel RA

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems to regularly assess and monitor the quality of service that people receive. The provider did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others. Regulation 17(1)(a)(b), (2)(b)(iv)(c)(i)

The enforcement action we took:

NOD to cancel RA

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure the required employment checks had been carried out prior to staff commencing employment at the service. Regulation 19 (1)(a)(b) (2)(a)(b)

The enforcement action we took:

NOD to cancel RA

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not sufficient to ensure the safety of people who used the service. Staff had not received adequate training to ensure they could support people safely. Regulation (1)(2)(a)

The enforcement action we took:

NOD to cancel RA