

Shaw Healthcare (Group) Limited

# Wellesley Road Care Home

## Inspection report

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## Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
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

This inspection took place on 19 and 29 September 2017 and was unannounced.

The last inspection was carried out in May 2016. The overall rating for the service was Requires Improvement. During our comprehensive inspection in September 2017 the service demonstrated to us that improvements had been made.

Wellesley Road Care Home is part of the Shaw Healthcare (Group) Limited. It provides accommodation, nursing and personal care for a maximum of 60 older people, most of whom have dementia. On the day of inspection there were 56 people using the service.

At the previous inspection in May 2016, the home did not have a registered manager. At this inspection we found a registered manager was now in place. 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 2008 and associated Regulations about how the service is run.

At our last inspection in May 2016, there were concerns around the amount of agency staff that were being used at the home. At this inspection we saw that the service had reduced the amount of agency staff. There was a continuous recruitment programme in place to employ more permanent staff. At the time of this inspection, the service had employed 34 permanent staff. There were three more vacancies to be filled. We saw that people's needs were being met.

A safe recruitment and selection process was in place. This ensured staff had the right skills and experience to support people. The provider carried out necessary checks prior to new staff commencing employment.

There were systems in place for the safe management of medicines. People received their medicines as prescribed. All prescribed medicines were available at the home and were stored securely. People told us they received their medicines when they needed.

We found that the registered provider had made improvements in their quality monitoring systems. The home had developed a range of ways to monitor the quality of the service in order to make improvements. A range of audits were carried out, including medicines, environmental, infection control and care plan audits. Where improvements had been recommended we saw that action had been taken.

Risks to people had been identified, assessed and reviewed. People receiving care told us they felt safe living at the home. There was a range of risk assessments, which covered the following areas: falls; skin integrity; and weight loss. There were control measures in place, which described how to keep people safe. The service had taken swift action to address issues we had identified with pressure mattresses.

The service met the legal requirements of the Mental Capacity Act 2005 in supporting people. We saw that staff sought and obtained people's consent before they offered help. People's mental capacity was assessed for particular decisions. Best interest meetings had been held with relatives and relevant health and care professionals where necessary.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We saw evidence that appropriate applications to restrict people's freedom had been submitted and the least restrictive options had been considered.

People were supported to meet their nutritional needs. They were able to make choices about the meals and drinks they wanted. We saw that alternative meals were provided.

People were supported to meet their health care needs and had access to a range of external health and care professionals. Healthcare professionals told us that people were referred to them in a timely manner so that people's needs were met.

People's privacy and dignity were respected. Staff cared for people in ways which recognised people's rights to make their own decisions.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service requires improvement in staffing.

Although we found that action had been taken to improve staffing, there was still a high turnover of agency staff.

People received their medicines as prescribed. Staff had received relevant medicine training and competency tests.

People were protected from abuse. There were procedures for managing safeguarding matters and staff had received training with regard to safeguarding.

Risks to people who used the service were identified and managed appropriately.

### Is the service effective?

Good ●

The service was effective.

We found that action had been taken to ensure staff received regular supervision.

People had access to sufficient food and drinks. People could choose what they ate. Alternative meals were offered.

Staff understood their obligations under the Mental Capacity Act 2005. People's rights to make choices about their care and treatment were respected.

People were supported by external health and care professionals who monitored their healthcare needs.

### Is the service caring?

Good ●

The service was caring.

People were treated with dignity and respect.

Staff understood people's individual needs.

People were encouraged to make choices around their care.  
Their religious and cultural needs were now supported.

### **Is the service responsive?**

The service was responsive.

People were involved in the development of their care plans.  
These were reviewed and changed as necessary.

People received person centred care. Staff followed people's care plans, which detailed people's preferences for care.

People knew how to make a complaint. The complaints procedure was made available to people and their relatives

**Good** ●

### **Is the service well-led?**

The service was well led.

We found that action had been taken to improve quality monitoring systems.

A registered manager was now in place. People and staff told us she was approachable.

There were systems in place to monitor the quality of the service. This ensured that shortfalls were identified and actioned.

**Good** ●

# 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 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.

The inspection took place on 19 and 29 September 2017 and was unannounced.

On the first day the inspection team consisted of one adult social care inspector, a bank inspector and a specialist nurse. On the second day the inspection team consisted of one adult social care inspector and an expert by experience. An expert by experience is someone who had personal experience with this type of service. The expert's area of expertise was people living with dementia and older people.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We were not able to speak with many people because some of them had complex needs. We spoke with eight people who lived at the home and one relative. We also spoke with the registered manager, operations manager, district nurse, two GPs, three nurses, two team leaders and eight care workers. We observed the meal service at lunch time and observed people being supported in the communal rooms. We looked around the home. We looked at care records of nine people, including care plans and risk assessments. We also reviewed other records relating to the running of the service, including recruitment files for nine staff, accident and incident records, Deprivation of Liberty Safeguard (DoLS) authorisations, safeguarding information, records of audits which had taken place and all records relating to the health and safety of the building.

# Is the service safe?

## Our findings

At our previous inspection in May 2016, the service was rated Requires Improvement for this key question because medicines were not being administered safely. We carried out a focussed inspection on 13 February 2017 and saw that improvements had been made. We found that the medicines were being managed safely and the breaches of the regulations identified in the warning notice had been met. At this inspection on 19 and 29 September 2017 we saw that these improvements had been sustained.

There were systems in place for the safe management of medicines. Medicines were administered by qualified staff. Staff administering medicines had received training and had regular competency reviews. We checked medicine administrations records (MAR) and found no unexplained gaps. We asked people if they received their medicines when they needed them and they confirmed this was the case. One person told us, "The GP prescribes my medicines and I get it on time". Another person said, "I do take medicines. Staff knock on my door and give [medicines] to me."

Medicines were stored in locked trolleys and at correct temperatures. Some medicines were prescribed to be taken 'as required', and there were protocols in place to make sure people received their medicines when required.

We asked people if they thought staff at the service knew how to keep them safe. One person told us, "Yes I feel safe. I have lots of friends". Another person said "I feel safe because staff come in and check on you. They come in and chat. Staff are very good." A relative also told us staff knew of potential risks to people and were able to care and keep people safe from potential harm.

At our last inspection in May 2016, we raised some concerns regarding staffing levels. At this inspection we saw that there was a continuous recruitment programme in place to employ more permanent staff. The service had employed 34 new permanent staff since our last inspection. This is because at the last inspection there had been a high turnover of agency staff. Also, since the last inspection some staff had left to pursue training and some of them were on temporary contracts. Generally staff reported improvements in staffing levels since the appointment of the new registered manager. Their feedback included, "We used to have a lot of agency staff but we have more permanent staff now", "Since [the registered manager] took over, staffing levels are okay" and "We used to have a lot of agency staff but we now have sufficient staffing."

Some staff suggested, having a floating staff member between units would help further. We observed care and support across the six units of the home. Although we found people's needs were met, we saw that staff were busy for long periods of time. Some people across the residential and nursing units required two staff to provide care. The registered manager told us there were two vacancies; a support worker and two night staff. Additionally, there was a vacancy for an assistant cook. These posts were being covered by long term agency staff. However, there was a recruitment drive at the time of our inspection.

Risks to people had been assessed and recorded. There were control measures in place, which described how to keep people safe. For example, a skin integrity plan of one person identified that they were at high

risk of developing pressure ulcers. Their control measures included the involvement of a tissue viability nurse (TVN), pressure relieving mattress, repositioning guidance, application of topical creams and daily skin checks. Equally, there were detailed control measures for other identified risks such as those related to nutrition, mobility, and medicines. We found that some pressure mattresses were not set at correct settings. The registered manager took immediate action during our inspection to resolve this matter.

People were protected from the risk of harm and abuse. There was an accessible safeguarding policy and procedure in place. Staff had received training in safeguarding. They were able to tell us how they would respond to safeguarding concerns, including reporting concerns to their manager, the local authority or Care Quality Commission (CQC).

Safe recruitment procedures were in place. The provider carried out necessary checks prior to new staff commencing employment. For example, at least two references were in place for all staff. This was also true of other checks including a disclosure and barring service checks (DBS) and current registration for nurses with the Nursing and Midwifery Council (NMC).

The provider ensured the maintenance of equipment used to provide personal care and health and safety checks were in place. We found up to date certificates to reflect fire inspections, gas safety checks, electrical appliances and other safety checks had been completed.

People had up to date personal emergency evacuation plans (PEEPS) in place which were accessible to staff in case of an emergency. The provider had a business continuity plan in place to ensure people continued to receive a service in the event of a disaster.



## Is the service effective?

### Our findings

At our previous inspection in May 2016, the home was rated Requires Improvement for this key question because the home did not provide regular supervision to staff. At this inspection we saw that improvements had been made. Staff were now receiving regular supervision.

The registered manager had a tracker in place for staff supervision and appraisals. Records showed that staff received bi-monthly supervisions and an annual appraisal. This was also confirmed by staff. One staff said, "Supervision is regular. The manager is supportive and approachable." Another staff said, "The manager is very supportive. She has an open door policy. She does not work at weekends but we can phone her." Staff also received group supervision. Previous topics of discussion included, staff training, key worker system, punctuality, medicines and safety checks. The registered manager told us the group supervision enabled staff to reflect on their work or relevant topics and learn from others.

New staff were inducted using the Care Certificate framework. The Care Certificate is a method of inducting care staff in the fundamental skills and knowledge expected within a care environment. New staff also completed orientation induction, which covered terms and conditions of employment, code of conduct and the philosophy of the organisation. A new member of staff told us, "The induction has been great. If I have any problems I speak to the manager. I find her to be professional, understanding and caring."

Staff had completed essential training. The operations manager shared with us a training matrix. This showed completed training and refresher training that had been scheduled for the year. Training included health and safety, infection control, moving and handling, safeguarding and food hygiene. A member of staff told us, "Training is great. I have been supported to complete a diploma in health and social care." Other staff members told us they had been supported to complete vocational qualifications relevant to their roles. This meant that staff were supported to obtain further qualifications appropriate to their work.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found the service was meeting the requirements of the MCA 2005, including DoLS. For example, some people were restricted from leaving the home without support and some had bedrails for their own safety. In these examples, DoLS authorisations had been put in place to protect people's liberty. The registered manager monitored pending applications for authorisations. The home had a DoLS tracker. This showed, when the mental capacity assessment was completed, when the DoLS application was submitted and

authorised. Where an application was pending, this was monitored. At the time of this inspection, there were 15 people who were legally deprived of their liberty.

People were supported to have nutritious food and drink. We checked whether people were happy with meals and choices available. One person told us, "Food is nice here. You choose what you want. I get enough food." Another person said, "I do have a choice. I have scrambled egg and I could choose bacon and toast." This was also confirmed by relatives we spoke with. We asked relatives if they thought people were well nourished and provided with the food they liked. One relative told us, "Yes, I think [my relative] gets plenty of food. I recently learned I can eat with [my relative]".

People's nutritional needs were assessed and plans were put in place to support them with their dietary needs. For example, one person in the home had a vegan diet and we saw this person was offered vegetable stews, which they liked. The home had 20 people on soft diets which included mashed vegetables, meat and fish, and pureed meals. There was guidance in people's records and in the kitchen. This described the texture of food and how this should look. Kitchen staff were aware of people's individual dietary needs. A dietary notification sheet listed any special dietary requirements and people's likes and dislikes. This ensured that people's special dietary needs were met.

People had access to external health professionals when required. We asked people if staff supported them to see their GP or to get treatment. One person told us, "Of course they look after me. They would call the GP. I have no complaints. I am very happy here". We asked a healthcare professional if staff acted speedily when health concerns arise. The healthcare professional told us, "The staff know how to escalate in a timely fashion." A healthcare professional told that communication with the home could improve. The home was aware of this and the registered manager told us they were working to make improvements.

## Is the service caring?

### Our findings

We asked people if they thought the service was caring and we received positive feedback. One person told us, "Yes, they do care." Another person said, "They are very caring and I get on with all of them [staff]. I can have a joke and a laugh." A third person told us, "I get on quite well with staff. If something is wrong I tell them and they put it right." A relative said the care provided at Wellesley Home is "Ten stars and that all staff are kind, caring and considerate."

People told us their privacy and dignity was respected. One person told us, "Staff respect my privacy and dignity." Another person said, "My dignity is respected." We observed that staff ensured people's privacy and dignity were respected. For example, they knocked on people's doors and waited for permission before entering. Staff ensured curtains were drawn when attending to personal care. Staff offered people choices. For example, at mealtime we observed staff to be patient when assisting people with meals. Staff did not rush people, but rather encouraged them to eat a little at a time.

A survey that was carried out in March 2017 drew mostly positive feedback from people. Responses received included, 'the staff at the home are polite and treat me with respect', 'I am asked whether visitors to my home can come in', 'I am communicated to in a way that I understand and can respond to', 'my support worker helps me dress and maintain my appearance in the way I want', 'I am addressed by the name I wish to be known as', and 'I can discuss matters in private that are important to me.' This showed that people were asked their views and staff involved them in their care.

We observed courteous interactions between staff and people throughout the inspection. For example, we saw staff kneeling to allow eye level communication, and offering people reassurances where people were in pain or discomfort. Some people had special equipment to help them to maintain their independence. For example, we saw that some people used special beakers which had spouts to make it easier to drink. This meant that the service was responsive to people's individual needs.

People's religious and cultural needs were being met by staff. People told us they were supported to worship their chosen faith if they wished to. The registered manager told us that representatives of local churches visited the care home on a weekly basis to offer pastoral care. If people required support to visit their places of worship, this would be provided.

People and their relatives were involved in making decisions with end of life arrangements. People's preferences with end of life support had been recorded in their care plans. Information included how people wanted to be supported during end of life and funeral arrangements.

We observed that personal information was stored securely in locked cabinets. Relatives and people were asked of their permission before their confidential information was shared with others and we saw this documented in care files. This meant people could be assured their sensitive information was treated confidentially, carefully and in line with the Data Protection Act 1998.

## Is the service responsive?

### Our findings

People told us they received personalised care that was responsive to their needs. Their care plans were personal to them and cross referenced to other care records, such as risk assessments. The care plans included information about people's medical conditions and details about their likes and dislikes. One person told us, "I am happy here. I get to do [activities] with staff." Another person said, "Staff are always nice. I would complain to the manager if I had any issues." Professionals were also complimentary. One healthcare professional told us, "The home is responsive to [people's] needs. They contact us immediately if there are any concerns.

The service was responsive to people's needs. One person was at risk of developing pressure ulcers. Their skin integrity support plan instructed a four hourly repositioning schedule. We saw from the daily records that this care plan was followed. At the time of this inspection this person did not have pressure ulcers. Another person was at high risk of falls. There was a support plan, which was evaluated on a regular basis. This person had been referred to their GP and relevant professionals. Another person was at increased falls risk due to a complex medical condition. There was a support plan for the complex medical condition. There was also a mobility and bedrail support plan, which was linked to the complex medical condition.

We saw evidence that support plans were followed by staff and that care plans were updated accordingly. For example, we reviewed a care plan of a person who was at risk of losing weight. Their assessment highlighted their level of risk. We saw that the MUST score was correctly calculated, monthly weight checked, including a SALT assessment and swallowing guidelines. We confirmed from the person's care records and from speaking with staff that this care plan was being followed. Daily records gave full details of monitoring that was carried out by staff, such as two hourly checks, skin care and skin integrity checks.

People were supported to participate in activities. One person told us, "I am going to the sing song group this afternoon. I am encouraged to attend." Another person said, "I get my hair done." We asked one person what type of activities they were involved in. The person told us, "Working out words, dancing, exercise, and singing." We saw evidence people participated in activities. There was an activities support plan, where activities participated in were recorded.

People were able to share their opinions and views about the service through quarterly surveys. The results of surveys were analysed and action points were identified to improve the service. We looked at the analysis of a survey that was carried out in April 2017. Concerns had been raised regarding meal choices, activities, and quality of food. In all examples, we saw that action had been taken to make improvements. For example, an alternative meal was now being offered to improve choice and activity coordinators were tasked with organising trips for people who preferred to visit places in the community.

There were processes in place for people and their relatives to use if they needed to complain. There was a complaints policy in place. People and relatives told us they were aware of who to contact if they wanted to complain. We asked people who they would speak with if they had concerns. One person told us, "You can talk to staff. They are all friendly." Another person said, "I know I can speak to the manager or staff." All

complaints were logged and investigated in line with the provider's complaints policy and procedure.

## Is the service well-led?

### Our findings

At our inspection in May 2016 we found that the registered provider did not operate effective systems to monitor the quality and safety of the service. We required the provider to make improvements in their quality monitoring systems. At this inspection we found that the home had made improvements. People and their relatives were happy about the quality of service. One person said, "The home is [well-led] and the manager is friendly." Another person said, "I would rather be at home but I am happy here."

Following our last inspection in May 2016, the provider had recruited to the manager's post. There was a registered manager in place since August 2017. The manager had relevant experience in health and social care. There was a clear management structure in the home and staff understood their lines of responsibility. The management team was composed of the team leaders who were based in each unit, the registered manager, and an operations manager who visited the home on a weekly basis. We spoke with the operations manager and the registered manager. They both showed a commitment to providing people with a high quality service.

The registered manager and the operations manager were familiar with important operational aspects of the home. They shared with us how they were performing against key performance indicators (KPI). For example, one of the home's KPI was to ensure that all people were assessed of their risk of falls and that those at risk had a care plan with control measures. At this inspection we saw that the service was meeting this KPI. All falls had been recorded and analysed.

The home had developed a range of ways to monitor the quality of the service in order to make improvements. The home had quarterly meetings with the local authority to check performance against key performance indicators (KPIs) and general performance. We read minutes of the meeting held on 22 June 2017. This showed the local authority had input in the improvement initiatives at the home. We saw that improvements had been made in all the areas where we reported shortfalls, such as staff supervisions, reducing the use of agency staff, and quality monitoring.

There were bi-monthly visits by a representative from the provider's head office. We examined the audit that was carried out in May 2017. This was modelled around the CQC key questions; safe, effective, caring, responsive and well-led. For example, under safe, the audit had identified improvements in the evacuation procedures. Under the key question of effectiveness, the home had identified improvements in meeting people's nutritional needs. This was consistently applied to the remaining three key questions and for each question we saw that relevant improvements had been carried out as required.

There was an open and inclusive approach to running the home. Staff meetings were held regularly. The meetings kept staff updated with any changes in the home and allowed them to discuss any issues. Minutes showed a number of topics were discussed, including safeguarding, incidents, complaints and monthly progress of the improvement plan.

Services that provide health and social care to people are required to inform the CQC of important events

that happen in the home. The manager had informed us of events as they were legally required to do. This showed that they were aware of their responsibility to notify us of serious incidents so that we could ensure that appropriate action had been taken.