Kent County Council

West View Integrated Care Centre

Inspection report

Plummer Lane
Tenterden
Kent
TN30 6TX

Tel: 01580261500
Website: www.kent.gov.uk

Date of inspection visit:
14 March 2018

Date of publication:
02 August 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 14 March 2018 and was unannounced.

West View Integrated Care Centre 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.

West View Integrated Care Centre accommodates up to 60 people in one purpose built building. The service is split into four units. One of the units specialises in providing care to people living with dementia. The remaining three units accommodate people with people on respite breaks and people in receipt of rehabilitation.

At the time of our inspection a registered manager was not in place. The previous registered manager had left their post in November 2017. 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. The day to day running of the service was overseen by an acting manager.

People told us they felt safe at the service. However, we found that there were not always enough staff to meet people's needs. Risks to people had not been assessed in a timely fashion, this led to people having accidents and serious injuries before plans had been put in place to mitigate risks. Systems to learn from incidents had not been effective making people safer. New systems had been put in place but these were too new to be assessed for effectiveness. People's medicines were managed safely, however guidance for 'as and when' required medicines was not always available. We made a recommendation about this.

People's needs had not always been assessed before they entered the service. People's care plans had some person-centred elements. However, information was not recorded consistently and was stored in a number of folders which not all staff could access. Different systems were used across the units at the service leading to people being at risk of inconsistencies in support. We made a recommendation about this.

People took part in a range of activities. However, these could be restricted by staffing levels and would benefit from being expanded to include one to one activities for people.

The lack of a registered manager for a period of time had led to a lack of stable leadership. This had impacted the culture and oversight of the service. Audits of the quality or care delivered had been completed infrequently and these has not been effective in identifying shortfalls. Feedback from people was sought in a limited way, this could be expanded to encourage people to give their views of the service. Systems to drive improvement at the service had not been effective and had not identified issues which were impacting people's safety and quality of support.

People were supported by staff who treated them with kindness and compassion. People's dignity and privacy was respected by staff. Staff took the time to encourage people to eat and drink a balanced diet. People were supported to access health care support when required. When people were at the service for a short period of time there were clear goals set for them to progress. Staff worked in partnership with other agencies to meet people's needs and to support them to return home when appropriate.

People were supported to express themselves and staff used a range of communication tools to support this. People were supported to have maximum choice and control of their lives and staff supported people in the least restrictive way possible; the policies and systems in the service supported this. Visitors were welcomed and people were supported and encouraged to maintain relationships with loved ones. When people expressed concerns or made complaints these were responded to appropriately.

The premises was designed to meet the needs of people. All areas being wheelchair accessible and appropriate signage was used to support people living with dementia. Staff understood the need for infection control and worked in line with procedure and good practice. People were supported by staff who had been recruited safely. Staff had the training and support required to meet people's needs.

This is the first time the service has been rated requires improvement.

You can see what action we told the provider to take at the back of the full version of the report or We last inspected West View Integrated Care Centre in May 2017 when the provider met the regulations. At this inspection two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. You can see what action we have asked the provider to take at the end of the full report.

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 consistently safe.

Risks to people had not always been assessed in a timely way, which had impacted on people's wellbeing.

Staffing levels were not always sufficient to keep people safe.

Medicines were managed safely, however guidance for the use of 'as and when' required medicines was not always in place.

Systems to learn from incidents had been improved, but were yet to be fully embedded in practice.

Staff understood their responsibilities in relation to safeguarding people and took action about concerns.

Infection control measures were followed by all staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's needs were not always assessed quickly enough.

Staff had the training and support required to carry out their roles.

People had a range of choices around food and drink and were encouraged to remain hydrated.

Systems to support communication were disjointed and did not always support people having co-ordinated care.

The premises were designed to meet the needs of people.

People were asked for consent and people's capacity was assessed when required.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion.

Staff used a range of tools to communicate with people and to encourage them to express themselves.

People were supported in a way which promoted their independence, dignity and privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People received care which was person centred and delivered in the way they preferred. People's care plans did not always record information in an accessible way.

There were a range of activities offered to people. However, these were restricted due to staffing levels and would benefit from being expanded.

People's complaints and concerns were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

A lack of consistent leadership had impacted on the culture of the service.

There were quality auditing systems in place but these were infrequent and had not always been effective in identifying shortfalls.

Opportunities for people to give feedback on their experience of the service were limited and could be expanded.

There had not been consistent effective systems in place to drive improvement. Systems were being reviewed at the time of inspection but were not embedded into practice.

Staff worked in partnership with a range of other agencies to meet people's needs.

West View Integrated Care Centre

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 was prompted in part by a number of notifications of incidents following which people using the service died or sustained a serious injury. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls and assessments of people's needs. This inspection examined those risks.

We did not ask the provider to complete a Provider Information Return (PIR), because the inspection was brought forward due to our concerns. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

This inspection took place on 13 March 2018 and was unannounced. The inspection was carried out by two inspectors and a specialist advisor who was a nurse.

Before the inspection we reviewed information we held about the service. This included notifications of incidents that the acting team leader had sent us since our last inspection. These are events that happened in the service that the registered person is required to tell us about.

We met with six people who were staying at the service, some of whom were living there permanently, and others on short term stays. We spoke with two relatives, four staff members, the acting manager, team leader, advanced clinical practitioner and head of service. We looked at eight people's care plans and the

associated risk assessments and guidance. During the inspection we reviewed other records. These included ten staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Some people were unable to tell us about their experience of care at the service so 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 with us. We observed how people were supported and the activities they were engaged in.

The service was last inspected in May 2017 and was rated Good.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at the service, one person said, "The staff keep me safe and look after me." However, we found that people were not always kept safe.

Risks to people had been assessed and plans had been put in place to mitigate risks. However, on several occasions staff had not assessed the risks before people arrived at the service or when they arrived. As a result, people had had falls or serious injuries shortly after arriving at the service. Due to the fact staff were unaware of the risk no actions had been taken to keep people safe. On the day of the inspection we were shown new assessment documentation which had been developed and used for the most recent person to move into the service. The head of service told us it was now agreed that every person would have their needs and risks assessed prior to moving to the service.

One of the factors in staff being unable to complete initial risk assessments promptly was staffing levels. The acting manager and head of service had identified that staffing levels were not sufficient to keep people safe. Some changes had been made to staffing at the time of inspection, a team leader had been allocated to each unit to support consistent leadership. The head of service told us that it had been recommended to the provider to increase the number of carers on each unit. However, more than three months after inspection it was confirmed that no additional staffing had been agreed. The provider informed us they were considering options to improve staffing levels.

Risks to people were not assessed in a timely fashion placing people at risk of harm and there were not always enough staff to keep people safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
People were supported by staff who had been recruited using safe recruitment processes. Checks were completed of their past employment, references taken and disclosure and barring (DBS) checks carried out. DBS checks ensure that staff are suitable to work with vulnerable people. Staff from an agency run by the provider were used to cover short falls.

People were supported by staff who were trained to recognise different types of abuse and how to respond to concerns. Staff told us the signs they may see if someone was being abused and who they would report their concerns to. The acting manager had worked with the local authority safeguarding team to consider and investigate any safeguarding concerns.

People were supported to have their medicines by staff who were trained and had been assessed as competent to administer medicines. Staff had a good knowledge about what people's medicines were for and explained this to them when administering if they asked. Some people had medicines which were to be taken 'as and when' required (PRN.) On some units there were no PRN protocols in place. A PRN protocol would include details of what the medicine was used for, how the person would indicate they needed or wanted the medicines, the minimum time between doses and the maximum number of doses people could have in a day.

Some people on the unit were living with advanced dementia and could not tell staff if they required pain relief. Without guidance for staff about when to offer these medicines there was a risk that people would be given medicines before they were needed or too late to be effective. People were also prescribed PRN medicines for use if they became distress or agitated. People had not received large amounts of medicines. However there was a risk people would be given these medicines too soon rather than as a last resort. When people are distressed it is good practice to try a range of other ways to help them calm such as distraction before offering them medicines.

We recommend that PRN protocols are put in place for all 'as and when' required medicines.

Risks to the environment were assessed and plans were in place to mitigate them. Regular checks of the premises and equipment were completed. Action was taken quickly to resolve any issues and arrange for replacements if required. People had personal emergency evacuation plans (PEEPs) in place and regular fire drills. A PEEP sets out the specific physical and communication requirements that each person had to ensure that they could be safely evacuated from the service in the event of an emergency.

The service was clean and well-kept, and suitable measures had been implemented to prevent and control the spread of infection. There was sufficient levels of personal protective equipment (PPE) available, and we observed staff using PPE correctly.

Following the recent concerns, the acting manager and head of service had worked with the advanced clinical practitioner to develop systems to identify issues and near misses. The system was used by the management team to look at how the risk of the same issue reoccurring could be minimised. These systems were very new and had not been embedded into practice. As a result, it was not possible to ascertain if they would be effective in improving safety at the service.

Requires Improvement

Is the service effective?

Our findings

People and their loved ones told us that staff were trained and confident in the way they supported people. One relative said, "The staff certainly seem to know what they are doing. They certainly 'get' my loved one and know the best ways to support them. They seem to really understand dementia and how it impacts people."

However, we found the service was not consistently effective. People's needs had not been assessed before they began receiving support the service and for some time after they arrived. As a result, staff could not respond effectively to people's needs and ensure care and treatment were delivered in line with legislation and good practice. For example, staff had not identified the need for some people to have sensor mats by their beds or to use bed rails to prevent falls.

Two units on the ground floor were staffed by Kent County Council and the remaining two first floor units by NHS employees. This led to some confusion and inconsistency in documentation and systems. The advanced clinical practitioner and acting manager were working together to try and develop a more cohesive way of working but this was a work in progress.

Within each unit we found that information about people and their needs, was stored in a number of separate folders. Some information was only available to more senior staff and other information to all staff. This led to some staff not having all the information they needed about the people they supported. For example, when we asked staff about one person's health condition and if a health professional had been contacted we were told that information was held by team leaders in a separate folder. There was also a risk of information not being communicated effectively across teams.

We recommend the service review their systems, based on current best practice, for communicating and recording information relating to people's care needs.

Staff told us the training they received was good and supported them in their role. One staff member told us they enjoyed the dementia training, and found it beneficial when working with people on the dementia unit. They told us the training gave them more information about the condition, and what to expect as a result. Staff told us the training was beneficial for the people they supported, as it enabled them to support people better, such as encouraging them to complete puzzles, or understanding the comfort a doll could bring to the person. Another staff member told us the enablement training was particularly good, as it reaffirmed to them that they needed to give people the opportunity and encouragement to be more independent. Staff told us this was especially helpful for people who attended the service for respite or rehabilitation.

People were supported to eat and drink sufficient amounts to maintain a balanced diet. There was a menu, in word and pictorial format which had been updated to reflect the days food choices. Staff told us several breakfast options were laid out for people, and people were encouraged to choose what they wanted. Lunch was a pleasant affair, with people laughing and joking amongst themselves and with staff. Staff prompted people discreetly during lunch, and supported them when necessary. Staff asked people if they

had eaten enough, and if they had enjoyed their lunch to which everyone confirmed they did. One member of staff noticed that a person was not drinking their cup of tea. They sat with the person, held hands and chatted to them. While they were chatting, they encouraged them to drink by holding their cup with them and bringing it to their mouth. Over a period of time the person finished their drink.

Peoples weight was checked regularly, and action taken when there were concerns that people had lost or gained significant weight. One person had been supported to see the GP following a weight loss, and the service had recorded their food and fluid intake to report to the relevant healthcare professional. Others had been put on food fortification supplements to maintain weight. This had followed efforts from the service to use more conventional methods to gain weight, which the person disliked, such as adding cream to food.

People were supported to access other health professionals such as GPs, physiotherapists, speech and language teams and occupational therapists when required. Advice received was recorded in their care plans and followed by staff.

People were given choices throughout the inspection and staff asked people for consent before giving them support. 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 decisions made on their behalf must be in their best interests and be 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Applications for DoLS authorisations had been made when required. Staff had completed capacity assessments for people relating to specific decisions. When people were found to lack capacity, decisions had been made in their best interest. For example, some people had best interest decisions made about them being supported by the service until they were well enough to decide for themselves or go home.

People's needs were met by the design and decoration of the service. Corridors had been purpose built to accommodate wheelchairs. There was clear signage on doors to indicate the use of the room for people who may forget the use of the room. The dementia unit had people's photographs and names on their doors to support people to find their rooms. People's rooms had been personalised with individual possessions, and some people had elected to bring their own furniture.

Good

Is the service caring?

Our findings

People told us they felt the staff were kind and caring towards them. During our inspection, we observed a number of kind interactions between staff and people, with both parties smiling and laughing often. One staff member told us, "We [staff and people] have good banter, we know who would appreciate it and who wouldn't. We build a good rapport with people."

People were treated with kindness, respect and compassion. During our inspection, we observed a number of kind, supportive interactions between staff and people. For example, one person told staff they were tired, to which staff asked if the person wanted to rest in bed. They supported the person gently to their room, showing them their photograph on the bedroom door as they entered to show the person it was their room. The staff member ensured the person was settled in bed, and gently covered them before leaving them to rest. Another person was celebrating their birthday on the day of our inspection. Staff had decorated the communal area, and we observed staff chatting and laughing with the person about their birthday presents.

One person loved animals and staff told us one of the resident cats could always be found in their room. When we went into the persons room, they were smiling and told us they were pleased that the cat was sleeping on their bed. Staff told us people enjoyed the companionship having a cat brought. People were encouraged to express their views and be involved in decisions about their care and support. People told us they chose what they wore, and what they ate on a daily basis. Staff told us of one person, "(name) likes a bath. They like feeling pampered."

Visitors were welcomed and staff had built up positive relationships with them. When a person came into to see their loved one, staff greeted them by their first name and chatted to them about how they had been since their last visit. The visitor had brought some snacks for them and their loved one. They went to the kitchen area and helped themselves to plates and cutlery for their food. They sat with their loved one and ate. Each member of staff who passed by said 'hello' and often commented on how nice the snacks looked and how nice it was to see them.

People's privacy, dignity and independence was respected and promoted. Staff recognised the importance of respecting people's personal space. Staff knocked on people's doors, and waited for permission before entering. If people were unable to communicate, staff told us they would make their presence known to the person, and if there was an indication they did not want support, staff would return later. Staff asked and supported people to use the toilet in a lowered voice, and ensured doors were closed when they supported people with personal care. Staff used pictures and gestures to encourage people to express themselves. They were very patient with people giving them plenty of time to make their needs known and responding quickly to any requests.

People's personal information was kept confidential. Written information containing private information was stored securely when not in use, and any information held on computer was password protected.

Requires Improvement

Is the service responsive?

Our findings

People and their loved ones told us that their care was delivered in the way they preferred and that staff understood their needs well. Staff told us, "We try to get to know people quickly as some of them are only here for a short time and it is important we make that stay as nice as it can be."

Each person had a care plan which gave staff guidance about the level of support they needed and how they preferred to be supported. However, the information recorded in the plans was not always consistent. For example, one person's care plan around drinks stated they may use a different word for the drink they wanted due to living with dementia. This information was not recorded in the person's care plan around communication. Staff agreed the person could also use a different word for other things but this was not shown in their plan. Some documents had also been copied and pasted as they referred to 'he' in a plan for a female. The team leader on shift changed this once it had been pointed out.

Care plans gave details of people's life history, who was important to them and how they had come to be at the service. The majority of people stayed at the service for short term support, their care plans had an aim of the stay. They also had a plan of the steps the person needed to go through in order to be able to return home. This included other professionals to be involved and allocated actions to staff. People received personalised care from staff who tailored their interactions to each person and their needs. Staff spoke about people, their lives and families. Staff knew what people enjoyed doing and how they liked to be supported.

People took part in a range of activities in each unit. A notice board displayed visiting performers and upcoming events. There were craft activities available such as knitting or colouring. There were reminiscence areas where people could sit and look at old photos or items. The chairs were set in a semi-circle, around a simulated fire place to encourage people to chat and create a homely feel. Staff told us they would like to do more one to one activities with people, but they did not have the time. The acting manager told us they hoped this would improve when the increased staffing was in place.

People were encouraged to maintain relationships with friends and family when staying at the service. There were areas where people could meet in private and people could go for walks in the grounds or to the local village. People were supported to keep their loved ones informed of their progress and possible dates for them to return home.

People told us they knew who to speak to if they were unhappy and that they would report any concerns. Complaints policy and procedure was displayed throughout the service including an easy read version. When complaints had been received, they were responded to appropriately, the outcome was recorded and reviewed for any learning.
When possible, people were supported to stay at the service for until the end of their life. At the time of the inspection no one was in receipt of end of life care.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection a registered manager was not in post, which is a condition of the service's registration. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The previous registered manager had left the service in November 2017 and the provider had failed to employ a replacement.

The service was being run on a day to day basis by an acting manager with the support of head of services from the provider. The acting manager had worked at the service for some time, but was new to the manager role and lacked experience in some tasks. Staff told us, "The manager is really good and you can always go to them, they will do their best, but they just have too much to do." The contrasts between the working styles and systems on the two floors had impacted the culture of the service. As a result, some staff were left feeling confused about the best way to do things. Recent incidents, concerns and staffing levels had also impacted on staff morale.

Audits were completed to monitor the quality of care. However, these had been infrequent and not identified the shortfalls found in this report or the risks related to the lack of early assessment. Feedback from people was only sought at the end of a short-term stay. As a result, concerns were not identified until the person had left the service, and so could not be resolved. People who stayed at the service for a longer period did not have an opportunity to give feedback.

Systems to recognise opportunities for learning and improvement had not been effective. There had been a large number of incidents relating to people falling soon after entering the service and no action had been taken to identify why this was happening. Once CQC and the local safeguarding team became involved it became clear that assessments were not being completed and action was not taken by the service. At the time of inspection new systems were being developed and implemented to learn lessons and drive improvement. However, these were not yet in place and so we were unable to ascertain if they would be effective.

The provider had failed to establish and operate systems to assess, monitor and improve the quality and safety of the services provided. Not all risks had been assessed and mitigated in a timely fashion. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff worked in partnership with other agencies to meet the needs of people. Staff made referrals to the relevant professional to enable people to return to their homes in the time agreed. This involved working with physiotherapy teams and occupational therapy teams to look at support for the person whilst at the service and any modifications that were needed to allow them to go home safely.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so people, visitors and those seeking information about a service can be

informed of our judgements. The provider had displayed the rating conspicuously in the service and there was a link on the provider's website to the latest CQC report. The acting manager was aware of their responsibility in relation to the CQC registration requirements, and had notified us of events that had occurred within the service so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. The manager was aware of the Duty of Candour, which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred.

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 Risks to people were not assessed in a timely fashion placing people at risk of harm and there were not always enough staff to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish and operate systems to assess, monitor and improve the quality and safety of the services provided. Not all risks had been assessed and mitigated in a timely fashion.