

The Fremantle Trust

# Sir Aubrey Ward House

## Inspection report

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13 March 2019

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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?

Good ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

# Summary of findings

## Overall summary

About the service: Sir Aubrey Ward House is a residential care home that was providing personal and nursing care to 58 people aged 65 and over at the time of the inspection.

People's experience of using this service:

Records at the service were not always robust and required improvements to ensure accurate information was recorded in relation to people's care.

- People's confidential information was not stored securely.
- Care plans we viewed were not always consistent with the care and support being delivered.
- Medicines were not always managed effectively.
- Systems and management plans were not always in place to manage the risks associated with people's behaviour.
- Staff were provided with training and supervision. However, some staff we spoke with told us they could not remember when they last had a supervision.
- The service's infection control policy was not upheld. We saw care staff with long fingernails, and wearing rings and several bracelets.
- People told us they enjoyed the food at the service. Where people were at risk of malnutrition appropriate steps were taken.
- The environment was adapted to suit the needs of people living there.
- People were treated in a dignified and caring way.
- End of life care was discussed with people and where appropriate their families.
- Activities were available for people to avoid social isolation.
- Complaints were recorded and responded to appropriately.
- Systems were in place to review the quality of care including feedback questionnaires and meetings.
- Where appropriate notifications were sent to CQC.

Rating at last inspection:

- At the last inspection the service was rated Good (the report was published on 25 June 2016).

Why we inspected:

- This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.

Follow up:

- We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care. Further inspections will be planned for future dates.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

## 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  
Details are in our Safe findings below.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective  
Details are in our Effective findings below.

**Requires Improvement** ●

### Is the service caring?

The service was caring  
Details are in our Caring findings below.

**Good** ●

### Is the service responsive?

The service was not always responsive  
Details are in our Responsive findings below.

**Requires Improvement** ●

### Is the service well-led?

The service was not always well-led  
Details are in our Well-Led findings below.

**Requires Improvement** ●

# Sir Aubrey Ward House

## Detailed findings

### Background to this inspection

#### The 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 was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

#### Inspection team:

- Our inspection was completed by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Our expert by experience had knowledge about personal care of adults using this type of service.

#### Service and service type:

- This service is a care home that provides personal care for older adults some of whom may be living with dementia.
- On the day of the inspection the person employed to manage the service was not present when we arrived. The deputy manager assisted us until the manager was contacted.
- The service did not have a manager registered with the Care Quality Commission. However, the person managing the service had applied to become the registered manager at the service.

#### Notice of inspection:

- Our inspection was unannounced.
- The inspection took place on 11 and 13 March 2019.

#### What we did:

- Our inspection was informed by information we held about the service including notifications that the service sent us.
- We asked the provider to complete a Provider Information Return. 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 any improvements they plan to make.

- We spoke with the person managing the service, the deputy manager, two assistant managers, four care staff, the activity coordinator a visiting GP and two domestic staff. In addition, we spoke with one visiting relative and seven people who used the service.
- We reviewed each person's medicine chart, five people's care plans and daily records, audits and other records relating to the way the service was managed.
- We requested additional information to be sent to us after our inspection that related to supervisions and monitoring of people following an injury. We have not received all of this information at the time of writing this report.

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

RI: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Systems and processes to safeguard people from the risk of abuse:

- We were notified of an incident that occurred at the service. One person was found unconscious in the early hours of 7 March 2019 with a head injury on the bedroom floor of a person who had behaviours that challenged. One member of staff we spoke with reported the person had the ability to get out of bed, and to use their walking stick to attack people. We saw there were no records of any previous falls for the person found on the floor and they were independently mobile. We spoke with the person's relative during our inspection and they told us, "I am fobbed off and am not sure what happened that night." We discussed this with the manager and they said they would speak with the relative when they next visited to discuss the incident and offer them reassurance. We saw there had been another incident in July 2018 when the person with behaviours that challenged hit another person with their walking stick. This demonstrated the service did not update and re assess the risks associated with people's challenging behaviours.
- Staff we spoke with told us they had received safeguarding training and were able to tell us what action they would take in response to witnessing abuse, saying they would escalate their concerns via the provider's management structure. The staff we spoke with required some prompting with regard to contacting outside agencies and then mentioned CQC or the police, although they did not mention the local authority safeguarding team.
- People told us they felt safe "Because you are (safe) you know you just trust people" and "The security is very good and we have got people to look after us which we can't do ourselves."

Assessing risk, safety monitoring and management:

- Support files viewed contained assessments relating to moving and handling, falls, malnutrition and dehydration.
- However, two people who had behaviours that challenged did not have a specific risk assessment in place in relation to how staff managed the behaviours on a day to day basis. We saw in an incident record several incidents that had occurred. For example, we saw one person had 16 incidents of mainly physical aggression towards staff this year and many more throughout 2018.
- Records showed that the person had been referred to the community mental health team on 5/11/2018, but there were no details of the outcome of the referral. The person had been referred to the GP on 6/3/2019. We did not see a behaviour management plan that had been developed by an appropriate professional.
- Staff were asked how they managed the behaviours and they told us, "By word of mouth to other staff to tell them about the behaviours really." Another member of staff told us there was no written guidance and they said, "All staff try different ways."
- We were aware of two people who fell and sustained head injuries. The notifications we received told us

hourly observations were being completed for the two people. We requested to see the observation charts that staff were completing. We were given a form that said 'on enhanced observations'. We had no specific evidence that hourly observations were being completed for both people.

#### Using medicines safely:

- We found medicines were not always managed safely. For example, one person's controlled medicine on 4 and 5 March 2019 had not been signed as administered on the Medication Administration Record (MAR), another person's prescribed supplement drink was not available from 22 February until 3 March and one person did not have any stock of their eye drops on 25 February. We discussed this with the person managing the service during our feedback and they said they will look into this.

#### Preventing and controlling infection:

- We found staff did not adhere to the provider's infection control policy which stated. 'Nothing should be worn that compromise the safety of people being cared for, a plain ring may be worn but should be considered during risk assessment'. We saw two members of staff wearing several rings and bracelets and also had extremely long nails. This would put people at risk with poor hand nail hygiene and would also prove a risk to people's skin during personal care. We discussed this with the manager during our inspection.
- The premises were clean and free from odour. Two domestic staff were carrying out cleaning duties on both days of our inspection. There were appropriate hand gels and aprons for staff to use.

#### Learning lessons when things go wrong:

- Incidents and accidents were recorded. However, we did not see any actions were taken to prevent reoccurrence. We refer to people who had become aggressive towards other people and staff.
- We did not see that learning was shared across the service to ensure that staff were aware of any actions. For example, we were told there was "no written guidance" and staff said, "All staff try different ways" (to manage behaviours which challenged). This put staff and people living at the service at risk of inconsistent support which may in turn have exacerbated certain behaviours.

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

#### Staffing and recruitment:

- The manager told us staffing levels were four staff on one unit, two staff on a smaller unit with only 10 people and three staff on another unit where people were more independent.
- We received mixed views from staff and relatives about the level of staffing. One member of staff we spoke with said there were enough staff to meet people's needs. The other member of staff said staffing levels were "Terrible". They described that there were sometimes only two or three members of staff on one unit instead of four that the manager had stated. They described an incident when they were asked to provide cover for one unit as one of the agency staff wanted to put the rubbish out. They went on to say there were several incidents of low staffing levels every week and that management could try harder to recruit. We asked if there were enough staff on duty at night and they said "It all depends who is on duty. Some days we come in and find people in wet and soiled beds." Staffing levels were discussed with a relative we spoke with and they told us "One day I visited [my relative] the staff did not know I was here and [my relative] was left on his own in the dining room for nearly an hour before a member of staff came to see him." We found staffing levels to be adequate during our two-day inspection and the number of staff on duty as confirmed by the rota and manager.
- The provider operated effective and safe recruitment practices when employing new staff. This included requesting references and checks with the Disclosure and Barring Service (DBS).





## Is the service effective?

### Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

RI: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:

- Information about people's choices and needs had been obtained through pre-admission assessments. This was to ensure that they knew the service could meet their needs before they moved in.
- The pre-assessment included information about their medical history, communication, social, physical and personal care needs. This included what support people needed with their care. Information from the pre-assessment was then used to develop care plans.

Staff support: induction, training, skills and experience:

- People told us that they felt staff were competent in their role. One person said, "They seem to be yes, I can't tell completely but yes they seem to be knowledgeable." Another person had a different view "The care staff do not have the health and safety knowledge, I fell over and the care staff had to sit me down and I had to wait to see the nurse to take care of my injury."
- Staff received induction training which included the care certificate and refresher training when required. We checked the training matrix and found that staff had access to a wide range of training including moving and handling and infection control.
- Some staff we spoke with told us they could not remember when they last had a supervision with their line manager. One member of staff who had been working at the service for 15 months reported that they had received a probation review after two and six months, but had not had any formal appraisal or supervision since.
- Another member of staff said their appraisal was completed without their line manager even speaking with them and they could not remember when they last had a supervision. We requested to see the supervision matrix during our inspection. However, this could not be located. We requested this to be sent to us following our inspection. We have received the supervision matrix which confirmed a total of 13 members of staff had not received any supervision for over four months. The provider's policy stated that staff should receive supervision every 12 weeks. Probationary staff should receive a supervision weekly for one month, fortnightly until 10 week review and monthly until a 20-week review.

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

Supporting people to eat and drink enough to maintain a balanced diet:

- People told us the food was good "Yes no problem about the food", "If I don't want what's on offer I get a choice from a food menu" and "I like some of it, if I don't like it I just eat it." We saw that records were kept in

people's daily record folder of the food and drink they had consumed or been offered throughout the day.

- People at risk of malnutrition had their weight recorded and were referred to the relevant healthcare professional when required. However, we found advice was not always followed from healthcare professionals. For example, to ensure weight was recorded and to offer supplements.

Staff working with other agencies to provide consistent, effective, timely care:

- People were referred to other agencies if additional healthcare was required. We saw the community nurse visited the service to support people. However, staff told us sometimes they (community nurse) came in to attend to someone and the services staff did not even know they had been. We were aware and staff told us, one person had recently had their catheter changed. However, there was no recording of this in the person's care plan.

Adapting service, design, decoration to meet people's needs:

- The environment was designed to meet the needs of people who lived there. The corridors were wide and were fitted with rails to aid with mobility. There was a wheelchair accessible central garden area with furniture, gazebo and raised flower beds. People's ensuite bathrooms were adapted to support people's independence.

Supporting people to live healthier lives, access healthcare services and support:

- People told us they received healthcare support when needed. Records seen indicated that people had access to healthcare services and professionals such as GPs opticians, hospital specialists and community mental health teams.

Ensuring consent to care and treatment in line with law and guidance:

- 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
- We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
- Staff had received training in the Mental Capacity Act and told us how they sought people's consent before supporting people and what they did if they refused. "You give them time, go back later. It's their choice." We found that whilst DoLS applications had been requested as required, these had not been followed up on. We saw several people had applications made as far back as 2016 and we did not see any evidence that these had been followed up. This meant the provider could not be assured that people's liberty could be restricted legally.
- In addition, we saw one person had a DoLS in place dated 10 January 2019. There were four conditions relating to the order but no accompanying plan to describe how the condition would be met.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

# Is the service caring?

## Our findings

Caring- this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity:

- The service promoted care practices in a non-discriminatory way where all people were valued as individuals regardless of disability, race, gender, or religious beliefs. We saw that people were offered a choice of male or female staff to support them.
- People told us the staff were caring. Comments we received were, "Yes they are caring", I have never experienced otherwise they are kind what more could you ask for." One person told us they were mostly caring. We asked the person to expand on this and they said, "Well since I have not been well one or two of them have 'had a go at me'. The staff think I am putting it on when I couldn't do things, but I was not. When I was not well I thought I could not go in the dining room and have lunch but the staff insisted that I go. I told them I can't go in and they said...Oh yes you can."
- During our inspection we observed some good caring interactions between staff and people. Staff knew people and developed good relationships with them.

Supporting people to express their views and be involved in making decisions about their care:

- We saw that reviews took place with people and their relatives when appropriate. We observed staff involved people in decisions around their day on a daily basis. For example, asking people if they wanted to join in activities and where they wanted to have their lunch.

Respecting and promoting people's privacy, dignity and independence:

- People told us they were treated with dignity and respect. One person told us, "Yes they knock on my door, I can't draw the curtains so I ask the staff and they do it for me because my arm is in a sling." Another person told us, "They don't just walk into my room, they knock first or poke their head in a little bit and ask me if I am alright." All personal care was delivered with the doors closed. We observed staff knocking on doors before entering.

## Is the service responsive?

### Our findings

Responsive – this means we looked for evidence that the service met people's needs

RI: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

- Care plans did not always record the communication aids people required such as glasses and hearing aids. The service therefore did not meet the Accessible Information Standard (AIS). The service had not ensured information was readily available for people with communication needs because of a disability, impairment or sensory loss such as large fonts or pictorial formats.
- The service was not always responsive to people's needs. Care plans did not adequately provide accurate and sufficient information to ensure that support met the needs of people living at the service. For example, one care plan we viewed stated 'requires catheter to be drained and urine measured and recorded'. We asked staff if we could view the chart they used to record this. Staff told us they did not know this should be done and they do not record the person's urine output.
- Another person's care plan stated 'will require repositioning every two hours to prevent pressure sores' dated 20 November 2018. We saw the review dated 23 February 2019 which said 'no changes'. We asked to see the repositioning chart. However, staff told us "we do not reposition [name] as their legs are constricted." We did not see any reference to this in the person's care plan.
- A third care plan we saw stated the person was to have their weight monitored due to significant weight loss. We were told this could not be carried out as the person could not sit in the scales. In addition, the person had been prescribed a dietary supplement by the hospital dietician to ensure they received adequate nutrients. We noted the supplement had been out of stock for ten days. We discussed our findings with the person managing the service. They told us they would look into this and it had been difficult 'with the care plans' as there were currently two versions in use. We were told the service's head office were in the process of updating care plans to a new version. This put people at risk of not receiving current up to date care if staff are not sure what version of care plan they should be referring to.
- We also saw that two people who displayed aggressive and challenging behaviours did not have a management plan in place to identify how staff were to manage the behaviours. However, we saw a behaviour chart that recorded when incidents occurred.

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

- We received mixed views about the activities people could take part in. Comments we received were, "There is not very much activity going on", "Well so far I have not taken part in anything", "I am not a group person I am quite self-sufficient if there is something going on then I am always asked if I want to join in" and "I do the exercise club when its going on." We saw group activities during our inspection which people were

engaged in.

Improving care quality in response to complaints or concerns:

- Most people we spoke with were aware of who to make a complaint to. People told us "I would tell who is in charge", "I would tell someone in authority", "I don't know", "No I don't know" and "I would speak to the member of staff who is always covered up. She is rude." We saw complaints were responded to in a timely manner. There were no open complaints at the time of our inspection.

End of life care and support:

- We were told the service supported people during the end of their life with support from the community nursing team. At the time of our inspection there was no one receiving end of life care.

## Is the service well-led?

### Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

RI: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility:

- There had recently been several changes in the management of the service. At the time of our inspection the service did not have a manager who was registered with us. However, the person managing the service had applied to become the registered manager. We spoke with them and they told us "It has been a journey." The manager had been in post for six months.
- Improvements were required that related to accurate and up to date information in people's care plans. Care plans we viewed had conflicting information about the needs of people. For example, one care plan stated the person was to be repositioned every two hours. However, staff told us this was not being carried out as the person's legs were constricted. There was no information relating to this in the care plan.
- In another care plan it stated to record and measure urine output. The person had an indwelling catheter in situ due to urinary complications. Staff told us they did not know this should be completed and they had never recorded the person's urine output. We noted urine monitoring was advice given from the local hospital during the person's recent admission due to deteriorating health.
- Another care plan referred to weighing the person due to significant weight loss. Staff told us they were unable to weigh the person as they could no longer sit in the weighing scales. However, we did not see any other avenues explored in relation to confirming what the person's weight was. For example, measuring using Mid Upper Arm Circumference (MUAC).
- We were told there were currently two versions of care plans in use. One new version which had been created by the service's head office and the old version still in use. This caused considerable inconsistency relating to records and staff told us "It is difficult at the moment until the whole system is the same."
- Daily notes were not detailed and lacked meaningful information. For example, daily notes for one person who had been receiving palliative care stated. Family present, and the next recording of daily notes stated, waiting for the undertakers to arrive. There had been no information as to what time the person passed away or any information immediately leading up to their death. In addition, we saw daily notes were not stored securely and were kept in unlocked cupboards on each of the services units.
- Quality audits were completed monthly by a member of the service's quality audit team. We viewed the completed audits and found they had not highlighted the issues we found in relation to accurate updated information relating to current needs of people using the service. Audits of the quality and safety of the care provided were not effective in assessing monitoring and mitigating the risks relating to the health and welfare of people using the service.

- Incidents were recorded but we did not see any actions were taken to reduce the risk of incidents reoccurring. This was clearly identified in relation to incidents of challenging behaviour. For example, we saw the recording of what happened on several occasions. However, without a plan for staff to follow to manage challenging behaviour we could not see how the same behaviour repeating itself on a regular basis could be prevented.
- Records were not accurate, complete and contemporaneous in relation to care delivery.

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

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

- Although the new manager had not been in post long they were clear about their role and understood quality performance risks and regulatory requirements. In addition, the deputy manager had worked at the service for some time and understood their role and supported the manager in making improvements at the service.
- People we spoke with were unsure who managed the service but mentioned the unit managers and the deputy manager.
- Staff reported "The [deputy manager] is brilliant she knows the staff well and is kind, compassionate and hardworking; she is the backbone of this place. One member of staff said the new manager is "very nice but is not around much."
- We were told that the service was restricted to the number of incontinence pads they could use for people during the day and night. Staff were told at a recent meeting to leave people in wet pads at night because it is warmer for them. However, staff told us they ignored this advice.

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

- Surveys were sent out each year to people and relatives and actions taken as a result.
- Staff attended regular meetings to feedback on how improvements could be made at the service. The overall theme from the survey we saw was relatives were hoping things would improve as the standard of care had not been good this year.

Continuous learning and improving care:

Working in partnership with others:

- We saw the service worked in partnership with other agencies to provide healthcare support for people. The community nursing team and the local GP attended the service on a regular basis to support people.



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 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider did not act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.                                    |
| Regulated activity                                             | Regulation                                                                                                                                                                                                                      |
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider did not assess the risks to the health and safety of people using the service. The provider did not ensure the safe management of medicines. |
| Regulated activity                                             | Regulation                                                                                                                                                                                                                      |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not maintain secure accurate and contemporaneous records in respect of each service user.                                                        |
| Regulated activity                                             | Regulation                                                                                                                                                                                                                      |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff did not receive sufficient supervision and appraisal to enable them to carry out the duties they are employed to do.                                               |

