Swindon Borough Council

Whitbourne House

Inspection report

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Date of inspection visit:
11 September 2018

Date of publication:
10 October 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Whitbourne House on 11 September 2018. This was an unannounced inspection.

Whitbourne House 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. The home accommodates up to 41 people. On the day of the inspection there were 39 people living at the service.

There was no registered manager in post. 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 provider had appointed an operations manager who was registering with the CQC to become the registered manager.

Before the inspection we had received concerns citing staff shortages and poor leadership and management of the home. A month prior to our inspection the registered manager had left. The provider implemented changes to address some of the concerns which the management team were working through.

We found the provider had taken action to improve staffing levels and staff deployment. A staff rota consultation was in progress and staff were already seeing the positive impact of the changes.

The provider had made significant improvements to the environment by redecorating the home. The whole home was undergoing redecoration and the provider was working through an on-going plan for further improvements.

People did not always receive activities that met their needs and preferences. The management team told us they had a plan in place to improve activities. We found people's records were not always complete. Some of the provider's quality assurance systems had not identified the concerns we found.

People told us they felt safe living at Whitbourne House. Risks to people's well-being were assessed and managed safely to help them maintain their independency. Staff were aware of people's needs and followed guidance to keep them safe. Staff clearly understood how to safeguard people and protect their health and well-being. There were systems in place to manage people's medicines. People received their medicine as prescribed.

People had their needs assessed prior to living at Whitbourne House to ensure staff were able to meet people's needs. Staff worked with various local social and health care professionals. Referrals for specialist advice were submitted in a timely manner.

People were supported by staff that had the right skills and knowledge to fulfil their roles effectively. Staff told us they were well supported by the management team. Staff support was through regular supervisions (one to one meetings with their line manager), appraisals and team meetings to help them meet the needs of the people they cared for.

People living at Whitbourne House were supported to meet their nutritional needs and maintain an enjoyable and varied diet. Meal times were considered social events. We observed a pleasant dining experience during our inspection.

People told us they were treated with respect and their dignity was maintained. People were supported to maintain their independency. The home provided information including in accessible format to help people understand the care and support that was available to them. The provider had an equality and diversity policy which stated their commitment to equal opportunities and diversity. Staff knew how to support people without breaching their rights.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and report on what we find. The registered manager and staff had a good understanding of the MCA and applied its principles in their work. Where people were thought to lack capacity to make certain decisions, assessments had been completed in line with the principles of MCA. The registered manager and staff understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be deprived of their liberty for their own safety.

People knew how to complain and complaints were dealt with in line with the provider's complaints policy. Where people had received end of life care, staff had taken actions to ensure people would have as dignified and comfortable death as possible. End of life care was provided in a compassionate way.

People's input was valued and they were encouraged to feedback on the quality of the service and make suggestions for improvements. The operations manager had a clear plan to develop and further improve the home. The home had established links and partnerships with several multidisciplinary teams to support safe care provision.

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 was safe.

Staff understood safeguarding procedures.

Risks to people were assessed and risk management plans were in place to keep people safe.

The provider's systems on staff recruitment needed strengthening. This was being addressed

There were enough staff to keep people safe.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had the knowledge and skills to meet people's needs.

The MCA principles were followed and people were cared for in the least restrictive way.

People were supported to access healthcare support when needed.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect and supported to maintain their independence.

Staff knew how to maintain confidentiality.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive activities that met their needs and preferences. There was a plan in place to improve activities.

People's records were not always complete.

Staff understood people's needs and preferences. Staff were knowledgeable about the support people needed.

People knew how to raise concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were systems in place to monitor the quality and safety of the service and drive improvement. However, some of the systems were not always effective.

The leadership created a culture of openness that made people and staff feel included and supported.

Whitbourne House

Detailed findings

Background to this inspection

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

This inspection took place on 11 September 2018 and was unannounced. The inspection team consisted of 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 care service.

Before the inspection we reviewed the information we held about the service and the service provider. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We received feedback from four social and health care professional who regularly visited people living in the home. This was to obtain their views on the quality of the service provided to people and how the home was being managed. We reviewed previous inspection reports. We also obtained feedback from commissioners of the service.

We spoke with five people and two relatives. We looked at six people's care records and four medicine administration records (MAR). The methods we used to gather information included pathway tracking, which is capturing the experiences of a sample of people by following a person's route through the home and getting their views on their care. During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We spoke with the operations manager, the deputy manager and seven staff which included, care staff, domestic staff and catering staff. We reviewed a range of records relating to the management of the home. These included six staff files, quality assurance audits, minutes of meetings with people and staff, incident reports, complaints and compliments. In addition, we reviewed feedback from people who had used the service and their relatives.

Good

Is the service safe?

Our findings

People were supported by sufficient numbers of staff. Before the inspection, we had received concerns about staff shortages. People's relatives told us the home needed more staff. One relative said, "I think there short staffed at the moment". Another relative commented, "They could do with more staff during the day". Healthcare professionals also told us the home often looked like they needed more staff. One healthcare professional said, "The home seems to be understaffed and you have to wait some time to access records or be let out of the building". Another healthcare professional told us, "Low on staff on the ground floor, residents waking around, looking for someone and needing something a lot of the time".

However, staff told us that whilst they had worked short staffed before, there had been an improvement. Staff said, "[Manager] is changing the rotas, the rota changes were a bit stressful for me because of my children and school hours. To begin with we were worried but the manager talked to me and I explained and she was very good and changed some shifts that were difficult so now I think it will be ok for us" and "Sometimes we are short staffed but the seniors are good and will try to get someone else in, sometimes use agency".

Throughout our inspection we saw staff were busy but people were attended to without unnecessary delay. Call bells were answered in a timely way and staff took time to engage with people. Staff rotas showed there were times when staff had worked short before. However, there was a significant improvement and there were enough staff on duty to meet people's needs.

The provider had taken staff shortage concerns seriously and were reviewing staff deployment and staff rotas. A staff rota consultation was in progress and staff were looking forward to the outcome.

We found the provider's systems on staff recruitment needed improvement. The provider had a policy for safe recruitment practices. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable potential employees from working with vulnerable people. However, there was no clear process to ensure staff who had been transferred over from other providers had the necessary recruitment records in line with the provider's recruitment policy. We raised these concerns with the management team and they understood they needed to ensure that the necessary recruitment records were in place.

We asked people if they felt safe living at Whitbourne house and they told us, "Touch wood life's been good for me and I get on with everyone, that makes me feel safe" and "I am safe, I like it here".

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff had attended training in safeguarding vulnerable people and had good knowledge of the service's safeguarding procedures. Staff were aware of types and signs of possible abuse and their responsibility to report and record any concerns promptly. One member of staff said, "Safeguarding is about

protecting people from all sorts of abuse, mental, physical or sexual. I would always report to a senior on duty or to a manager and if I needed, to one of the senior managers. All the staff know this, there is a policy and it's in the office".

Risks to people were identified and risk management plans were in place to minimise and manage the risks and keep people safe. Some people had restricted mobility and information was provided to staff about how to support them when moving them around the home. Risk assessments included areas such as nutrition, falls, fire and moving and handling. Risk assessments were reviewed and updated promptly when people's needs changed. For example, one person became high risk of choking. The person was referred to the Speech and Language Team (SALT). Staff were advised to give the person pureed food and thickened fluids. This person's risk assessments and care plans were reviewed promptly to reflect the changes. People had Personal Evacuation Emergency Plans in place (PEEPs). These contained detailed information on people's mobility needs and additional support required in the event of a fire.

People received their medicines as prescribed and the home had safe medicine storage systems in place. The provider had a medicine policy in place which guided staff on how to administer and manage medicines safely. We observed staff administering medicines to people in line with their prescriptions. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given or, if not taken the reason why. People understood the reason and purpose of the medicines they were given.

The environment looked clean and equipment used to support people's care, for example, weight scales, wheelchairs, hoists and standing aids were clean and had been serviced in line with national recommendations. People's bedrooms and communal areas were clean. Staff were aware of the providers infection control polices and adhered to them.

The provider had a clear procedure for recording accidents and incidents. Accidents or incidents relating to people were documented, thoroughly investigated and actions were followed through to reduce the risk of further incidents occurring. Staff knew how to report and record incidents. One member of staff told us, "If there is an accident or something goes wrong we have to report it the same day".

The service learned from mistakes. Staff told us and records showed shortfalls were discussed with the aim of learning from them. For example, staff told us a lot of learning and changes had been implemented following our last inspection. We also found the recent changes in management had resulted in reviewing the way the provider engaged with staff and improved staff involvement.

Good

Is the service effective?

Our findings

People told us and records confirmed that people's needs were assessed before they came to live at Whitbourne House. This allowed gathering of the necessary information that formed the base of care planning process and ensure the home was appropriate to meet people's needs and expectations.

People received care from knowledgeable staff who had the right skills. Records showed staff had the right competencies and qualifications to enable them to provide support and meet people's needs effectively.

Records showed the induction training was linked to the Care Certificate standards. The Care Certificate is a set of nationally recognized standards to ensure all staff have the same induction and learn the same skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support. This included training for the role and shadowing an experienced member of staff. One member of staff commented, "Staff induction is detailed, they have a comprehensive book to work through. We have introductions to staff and residents, premises, fire, call bells, recording, policies".

Records showed and staff told us they received the provider's mandatory training before they started working at Whitbourne House. They were also supported to attend refresher sessions regularly. Mandatory training included; manual handling, dementia training, safeguarding, equality and diversity and fire safety.

Records showed staff received regular supervision sessions which was confirmed by staff. Supervision sessions enabled staff to discuss their personal development objectives and goals. Records also showed that staff discussed topics such as care plan updates, infection control, records keeping and staff allocation. One member of staff told us, "Staff supervision are every six to eight weeks for full time staff and as close to that as we can for part time staff. Appraisals are annually with a review at six months. It covers goal setting, objectives and training needs".

People's care records showed relevant health and social care professionals were involved with their care. People were supported to stay healthy and their care records described the support they needed. We saw the home had strong relationships with the mental health teams and advocacy teams. One healthcare professional told us, "I have always been contacted by the home if there have been any issues of concern".

People's dietary needs and preferences were documented and known by the chef and staff. The home kept a record of people's needs, likes and dislikes. Some people had special dietary needs and preferences. For example, people having soft food or thickened fluids where choking was a risk. The home contacted GP's, dieticians, speech and language therapists (SALT) as well as care home support if they had concerns over people's nutritional needs. Records showed people's weight was maintained. Drinks and snacks were available to people throughout the day.

Throughout the inspection we observed people had access to food and drinks of their choice. Where needed, people were encouraged to drink fluids. People told us they enjoyed the food and were able to make choices about what they had to eat. Comments included; "The food is good I take it as it comes. I was

a vegetarian, but I do eat meat chicken and fish, fish is my favourite and we do get fish here and no I don't get hungry at night", "The food is nice, they do it really well. I eat all of it and we get a good choice, my favourite is fish and chips" and "Yes, I like it here food is always good".

During the inspection we observed the midday meal experience on both floors. This was an enjoyable, social event where most people attended. There was conversation and chattering throughout. A two-course meal was served hot from the kitchen and looked 'home cooked' and appetising. People were offered a choice of drinks throughout their meal and, where required, received appropriate support. People were encouraged to eat and extra portions were available. We observed staff sitting with people and talking to them whilst supporting them to have their meals at a relaxed pace. Some people chose to have meals in their rooms and staff respected that. People had the same pleasant dining experience whereever they chose to eat their meal.

The Care Quality Commission (CQC) is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report our findings. The 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.

The registered manager and staff ensured that the rights of people who may lack mental capacity to make particular decisions were protected. Where people did not have capacity to make certain decisions, there was evidence of decisions being made on their behalf by those that were legally authorised to do so and were in a person's best interests.

Staff told us they understood the MCA. One member of staff said, "The MCA is about peoples' ability to make decisions. We have to explain to people what we are doing so that they can understand and give consent. If they lack capacity, others need to decide in their best interests and some have LPA (Legal Power of Attorney)". Another member of staff explained, "We need to see how people are each day. We give choices about their food and what they wear and what time they want to wake up. It depends how they are day to day, even every hour they could be completely different".

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 found the home met the requirements of DoLS. People who had DoLS in place were being supported in the least restrictive way. Staff had been trained and understood the requirements of the MCA and the specific requirements of the DoLS.

The provider often sought advice from Independent Mental Capacity Advocates (IMCAs). An IMCA is an advocate who has been specially trained to support people who are not able to make certain decisions for themselves and do not have family or friends who are able to speak for them. IMCAs do not make decisions and they are independent of the people who do make the decisions.

The provider had made some significant improvements to the general environment. The whole home was being redecorated and a new floor was in place. There were ongoing plans in place to make the home more dementia friendly. One member of staff told us, "The décor is already better, it looks so much nicer".

People's rooms were personalised and decorated with personal effects, furnished and adapted to meet their individual needs and preferences. Paintings, pictures and soft furnishings evidenced people were involved in

adapting their rooms. The general outlook of the home allowed free access to people who used equipment like wheelchairs. People could move around freely in the communal areas of the building and the gardens.

Good

Is the service caring?

Our findings

People received care from caring staff who knew people well. People's relatives complimented the care people received from staff. One relative said, "The staff here are fantastic, they will do anything in their power to help. Whatever you say to them, they take it on board". Another relative told us, "The staff know if she's not having a good day and they spend a bit of extra time with her".

We observed staff talking to people in a polite and respectful manner. They interacted with people as they went about their daily work stopping to say a few words to people as they passed by. People were given options and the time to consider decisions about their care. Throughout our inspection, we observed many caring interactions between staff and the people they were supporting. People's preferred names were used on all occasions and we saw warmth and affection being shown to people. The atmosphere was calm and pleasant.

Staff had a calm approach and made sure people were comfortable. We saw staff treated people respectfully and maintained their privacy. People received care in private. We saw staff knocking on people's doors and asking if they could go in. Staff told us how they protected people's dignity when giving personal care by making sure doors were closed, covering people appropriately and explaining what they were doing. One member of staff told us, "Privacy is important. For example, if someone is incontinent we take them discreetly to their room or bathroom to wash them and change them. We try to dress people in a dignified way".

People's care plans contained information and guidance on how best to communicate with people who had limitations to their communication. For example, one person's care plan stated the person needed time to verbalize their thoughts and they could get anxious about it. We saw staff took time with this person to ensure they understood them. Staff knew people's individual communication skills, abilities and preferences.

Staff spoke with us about promoting people's independence. One member of staff said, "We leave people to do as much as they can for themselves". Records showed people's independence was promoted. For example, one person's record emphasised on allowing enough time for the person to try and move with minimal support.

Staff were provided with guidance in relation to confidentiality and were aware of the provider's policy on confidentiality. One member of staff told us, "There are new regulations and we have had training in General Data Protection Regulation (GDPR). We know we must not disclose information over the phone and handovers must be in private. They have put a blind over the whiteboard so residents' information can't be seen by visitors in the office".

Throughout the inspection we saw staff were discreet and respected people's confidentiality. Records containing people's personal information were kept in the main office which was locked and only accessible to authorised persons. Some personal information was stored within a password protected computer. The

operations manager was well aware of the implementation of the GDPR. From May 2018, GDPR is the primary law regulating how companies protect information

The provider's equality and diversity policy was available in the home. This stated the provider's commitment to equal opportunities and diversity. This included cultural and religious backgrounds as well as people's gender and sexual orientation. Staff spoke to us about how they supported people. One member of staff told us, "We treat people equally and accept and respect cultural differences".

Requires Improvement

Is the service responsive?

Our findings

People had access to limited activities. In the morning we observed staff facilitating a ball game. A few people engaged and enjoyed the session. However, most of the people lacked the opportunity for experiencing any stimulating activities. The management team told us the activities coordinator had left and staff were providing activities going forward. People's activities records were not always complete. For example, one person's activity log was last completed on 15 June 2018. Another person's activities log had only six entries since the beginning of August.

Staff told us the activities needed improving. Staff comments included, "We have not long lost our activities coordinator, but we are not looking at getting anyone else. We the staff will be doing activities" and "Activities could improve. We need an activities coordinator or more staff to help with activities". One healthcare professional commented on the lack of activities. They said, "There seems to be a lack of stimulating activities going on and lots of residents congregate near the main entrance, some trying to leave through the front door. I am aware that attempts are being made to address that issue though".

People commented about activities. One person said, "No not really involved, not much to do but I do what I like". Another person told us, "I join at times but nothing much to do here". Records of family meetings showed activities had been discussed and people had been asked to put forward their activity choices. We spoke to the operations manager and they told us an activities plan was in progress which included taking people out for visits as well as arranging entertainers to come into the home.

People's care records contained detailed information about their health and social care needs. The provider used a 'This is Me' document which captured people's life histories including past work, social life, likes and dislikes which enabled staff to provide person centred care and respect people's preferences and interests. However, some people's 'This is Me' documents were not always completed.

The care plans included information about people's personal preferences and were focused on how staff should support individual people to meet their needs. For example, people's preferences about what time they preferred to get up or what food they liked to eat.

People's care plans covered areas such as personal care, eating and drinking, mobility, elimination and communication needs. We saw detailed daily records were maintained to monitor people's progress on each shift and had up to date information. It was clear people received up to date care. However, people's care plans were not always updated when people's needs changed to reflect the daily records of care. We discussed these concerns with the management team and they took immediate action to update the care plans.

The provider had a key worker system. A keyworker is a staff member responsible for overseeing the care a person receives and liaises with families and professionals involved in that person's care. This allowed staff to build relationships with people and their relatives and aimed at providing personalised care through consistency.

The management team ensured people's needs and any changes were communicated effectively amongst the staff. Information was shared between staff through daily handovers as well as staff meetings. This ensured important information was acted upon where necessary and recorded to ensure monitoring of people's progress. Staff shared information about any changes to care needs, activities attended, planned appointments and generally how people had spent their day. This meant staff received up to date information before providing care, maintaining consistency.

People and their relatives knew how to make a complaint and the provider had a complaints policy in place. People told us they knew who to complain to if they had any concerns. Records showed there had been complaints raised about poor communication and had been dealt with in line with the provider's policy.

People's preferences relating to end of life were recorded. This included funeral arrangements and preferences relating to support. People and their relatives, where appropriate, were involved in advanced decisions about their end of life care and this was recorded in their care plans. For example, one person had an advance end of life care (a plan of their wishes at the end of life) which stated they wished to be cremated. We saw the person and their family were involved in this decision. Staff described the importance of keeping people as comfortable as possible as they approached the end of their life. The home had links with a local hospice which supported staff in providing end of life support.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager in post. 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 provider had appointed an operations manager who was registering with the CQC to become the registered manager.

Prior to the inspection we had received concerns from whistle blowers around poor leadership and management. The registered manager had left in the last month. The home was being led by an operations manager who also led the provider's other home. There was a deputy manager who had been in post for a significant period of time.

Staff were appreciative of the positive changes the provider had put in place following the registered manager's departure. One member of staff told us, "The changes are good but I think they have been too abrupt. For example, changing the sitting room and dining room and getting rid of the bus stop. People were used to it and it threw them. But progress is in the right direction, they are positive and it is more homely now. But we are human beings after all and we need time to get used to things". Another member of staff said, "The changes all sound really positive, we will have more quality time and we will be able to provide more person-centred care".

People and their relatives told us the service was well managed, although the visibility of the leadership within the service was not evident from the feedback we received. One person said, "I don't know who the manager is, man or woman, but I think whoever it is they're doing a good job". Another person commented, "I don't know who the manager is but it's very good here". A person's relative told us, "The manager and deputy manager, I think they're doing a good job". Another relative said, "The new manager is good and making positive changes".

The provider had effective quality assurance systems in place to assess and monitor the quality of service provision. For example, quality audits including medicine safety, meal time and nutrition, health and safety as well as care plans. Some of the quality assurance systems were operated effectively and used to drive improvement in the service. However, the care plan audits had not identified the issues around updating care plans we found in people's records.

There was a clear management structure in place, with staff being aware of their roles and responsibilities. Staff felt that they could approach the management team or other senior staff with any concerns and told us that management were supportive and made themselves available.

People and their relatives were invited to develop the service being delivered. Records showed regular meetings for people and relatives were held where they could share their views on issues such as food, activities or any other views they wanted to discuss. These meetings were also used to discuss developments within the home which included the environmental changes. The provider had also

introduced a family newsletter as a way to share information.

Records showed the service worked in close partnership with the safeguarding team and multidisciplinary teams to support safe care provision. Advice was sought and referrals were made in a timely manner which allowed continuity of care. The provider sought for innovative ways to improve people's care through working closely with other local providers.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service. The management team was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events. They also understood and complied with their responsibilities under duty of candour, which places a duty on staff, the registered managers and the provider to act in an open way when people came to harm.