Mr A Y Chudary

Woolton Manor Care Home

Inspection report

Allerton Road
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29 November 2016
15 December 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 23 and 29th November 2016. The first day of the inspection was unannounced. The home were advised we would return week commencing 28th November 2016 but not the day we would return.

We carried out a third day of inspection on 15th December 2016. This was to check the provider was working towards an action plan they had given to us to address immediate concerns we had following the first two days of inspection. The provider was informed we would be returning but not the date on which we would do so.

Woolton Manor is registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury for up to 66 people. At the time of our inspection 23 people were receiving nursing care and 33 people residential care.

The home required a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The current manager had been working at the home since April 2016 but had not yet registered with CQC.

During our inspection, we identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulated Activities 2014 in respect of Regulation 9 Person centred care; 10 Dignity and respect; 12 Safe care and treatment; 13 Safeguarding service users from abuse; 16 Receiving and acting upon complaints, 17 Good governance and 18 Staffing, of the Health and Social Care Act 2014 Regulations.

You can see what action we told the provider to take at the back of the full version of the report.

The staffing in the home was insufficient to meet people's needs. The home did not always have appropriately trained staff on duty to meet people's specific care needs.

The care provided at the home was not always in accordance with people's care plans placing people at risk from harm due to poor care.

Medication was not safely managed and was not always available as prescribed.

The building and equipment in it were not always fit for purpose. We found unrestricted windows and dirty equipment in the home. We also found mould in cups and jugs left lying around that a person who may be confused could come into contact with.

Complaints were not always recorded and handled appropriately and the management audits and

processes in the home failed to recognise all of the concerns we identified during the inspection which meant that the home was not safely run.

On the third day of the inspection we saw that the provider had begun to take action to address some of the very serious concerns we had identified. The changes being made were new to the service and had not been fully implemented or embedded. We were therefore unable to judge whether they would be maintained and provided a consistent improvement to the service people received.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC.

The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location from the providers registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The building and premises were not maintained to an acceptable standard to keep people safe.

Risk assessments did not meet people's needs safely placing people at risk from potential harm.

Staff did not recognise safeguarding concerns and take appropriate action when it was required.

Is the service caring?

Inadequate

The service was not caring.

Staff did not treat people with dignity and respect at all times.

The way in which the environment, equipment and linens were maintained and looked after did not promote people's dignity.

People did not receive a respectful service that recognised them as individual.

Is the service responsive?

Inadequate

The service was not responsive.

People were not receiving appropriate care in accordance with their care plans putting them at risk from harm.

Complaints were not always recognised, recorded and managed appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The service does not have a registered manager.

The manager and the provider had a lack of awareness and oversight of the service.

Risks to people's health and safety were not acted upon in a timely manner.	

Woolton Manor Care Home

Detailed findings

Background to this inspection

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

We undertook a focused inspection of Woolton Manor on 23 and 29 November and 15 December 2016 which was unannounced. The inspection was carried out by an adult social care inspector, an adult social care inspection manager and a specialist advisor who was a registered nurse and a manager of a care service. A nurse from the Liverpool CCG (Clinical Commissioning Group) was also present during the inspection.

This inspection was carried out to follow up concerns that had been raised with CQC regarding the staffing levels and nursing care being provided at the home. CQC had only recently completed a comprehensive inspection in September 2016 and the concerns had been raised following this inspection. We found that breaches of two regulations we raised following the September 2016 inspection had not been addressed and found breaches of a further four regulations at this inspection. We inspected the service against four of the five questions we ask about services. This is because the service was not meeting legal requirements in relation to all of the four questions; is the service safe, caring, responsive and well-led?

Prior to visiting the service we spoke with and obtained information from the local authority safeguarding department, Liverpool Community Health Trust and Liverpool CCG. We reviewed the information we already held about the service and any feedback we had received including whistleblowing information and information from relatives of people living or who had lived at the home.

During the inspection we spoke with 15 people who lived at the home. This included speaking individually with seven people and holding a meeting attended by nine people, one of whom we had spoken with individually. We also spoke to nine relatives of people living at the home and five members of staff. We observed the care and support provided for a number of people who lived at the home and reviewed a range of documentation including care plans, wound care records, staff training records, policies and procedures, auditing records, health and safety records and other records relating to how the home is managed.

Inadequate

Is the service safe?

Our findings

We asked people who lived in the home if they felt safe living there and we received mixed responses. Some people said that they did feel safe and others said that they did not because the staff response when they needed support was slow. Comments we received from people included; "The staff are lovely and cope very well given the difficult circumstances" and "I'm left for hours in discomfort and pain because no one comes when I ring my call bell."

Prior to the inspection we became aware that a person who lived in the home had been able to leave the building unsupported and had been found by the police. This was because the front door lock was broken. This incident happened six days before the start of our inspection. On the first day of our inspection we were able to enter the building because the front door lock was still broken. This meant that people were still able to leave the building unsupported which could place them at unnecessary risk.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was because the provider had not done all that was reasonably practical to mitigate risks.

We raised concerns with the provider and the manager and the lock was fixed on the first day of the inspection. On the second day of the inspection we saw that a key pad was being fitted to other doors to keep people safe. On the third day of the inspection we saw that both the lock and key pad were working.

We saw a tin of 'Thick and Easy' in one person's bedroom that was labelled as belonging to another person. 'Thick and Easy' thickens food or drinks and is prescribed for individuals who have difficulty swallowing. In the lounge we found a tin of 'Thick and Easy' that was labelled for use by one person living at the home and saw that this was being used for two other people. This meant that people were being given medication that was not prescribed for them. We found another tin of 'Thick and Easy' in a second person's bedroom that belonged to them and had been stored without a lid on it. This meant that the medication was stored incorrectly and could become an infection risk.

In a third bedroom we saw a plastic pot containing medication. This was unattended and could pose a risk to people living at the home who were confused.

One person's care plan stated that they should have medication available to support them with end of life care. This medication was not available in the home. This meant that the person did not have access to the medication they may need to ensure they were pain free.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to ensure the proper and safe management of medicines.

During the inspection we walked around the building and we looked at the safety and security of the

premises. On the first floor we found four windows that were not restricted from fully opening. These windows opened upwards with the opening at approximately waist height. This meant that people could be at risk of falling out and harming themselves.

We saw a television in one person's bedroom that was balanced on a box on their chest of drawers. This was unsafe and could fall causing an accident.

On several occasions we saw cleaning trolleys containing cleaning products left unattended in corridors. This is a risk for people who may be confused. In the laundry room two drinking jugs contained chemicals. Neither jug was labelled and these were left unattended in the room. Not storing chemicals in the correct containers and in particular storing them in containers that can be used for drinks poses a risk to everyone in the home.

We looked around the home and found that in some areas infection control was poorly managed. We found a dirty stained hoist sling that was being used by people who lived in the home. We also found a pillow on a person's bed that was covered in what looked like dried blood and other body fluids. This pillow had been covered with a clean pillow case.

An unoccupied but unlocked bedroom contained a tray with a plastic jug of milk with a thick substance growing on top and cups with part of a drink in them that appeared to be growing mould. These could have been accessed by people who were confused and did not realise the dangers they presented.

We also saw what looked like faeces on the bedside rail cover of one person's bed. We checked later that day and found that it had not been cleaned and had to ask a staff member to clean it.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that the building was safe and adequately cleaned to prevent the spread of infection.

We looked at risk assessments in relation to people's care and found that they were often incomplete and hard to follow. For example we saw that one person had been identified as at risk as they had lost a significant amount of weight. The risk assessment in relation to this was incomplete. We then saw that this person's weight was recorded in three different places. The risk assessment identified them as having a stable weight. Other records showed that this person had lost 12.7kgs in the last two months. We questioned these records and were told that they were out of date. We asked that the person's weight was checked immediately and action taken to support them if this was required.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that risk assessments were adequately maintained to protect people from harm.

During the inspection we noticed that one person had severe and significant bruising to their hand and arm. When we questioned the staff, this bruising was unexplained. We were very concerned as staff had failed to recognise that this was a risk to the person and a safeguarding concern. At our request the staff reported and recorded the bruising.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that the staff team could recognise and respond to safeguarding concerns.

Prior to the inspection we had concerns raised to us regarding staffing levels and staff abilities and skills. At the inspection we found that a significant number of agency staff were being used in the home, some of whom did not have the skills and expertise to provide adequate care for people who lived there. We found that a nurse was regularly working at the home who was not competent in dealing with catheter care and there were people in the home who needed this support. This had been reported to CQC by health care professionals. We asked how the manager ensured that the agency staff had the correct skills. The manager gave us staff profiles that had been received from the agency but these did not identify the nursing skills individuals had.

Nearly everyone we spoke with in the home told us that there was not enough staff and that there was often agency staff who didn't know the people or how to care for them. One relative told us "There are days when there is little staff." A second relative told us that they had heard people asking to go to the toilet and being told they would have to wait as there were not enough staff.

We looked at the staff rotas for a four week period and saw that there were constant staff changes and that there were often fluctuating staffing levels. We also saw that one agency nurse was working 60 hours most weeks to provide the home with nursing cover.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that there was sufficient numbers of suitably qualified, competent and experienced staff available at all times to provide people with the care they need.

Inadequate

Is the service caring?

Our findings

We asked people who lived in the home their opinion of staff and the support they provided. People had differing opinions. Some people were very complimentary about the staff. They told us "The staff are nice and kind and lovely" and "The staff are very helpful." Other people had very different views. They said "Not one of the staff has a heart or any empathy with anyone" and "I've begged them in tears to take me to the commode and they just say wait."

We spoke with a number of relatives who raised concerns about the care that staff provided. One relative told us that they had to "keep an eye" on how often their relatives bedding was changed as at times it had been unchanged for over a month. Another relative told us that staff had failed to help their relative celebrate an important birthday. This had included not passing on a birthday card despite promising to do so and sharing out a cake made by a family member but not telling people what was being celebrated. A third relative told us that their relative had been admitted to hospital for two days and staff from Woolton Manor had not informed family so that they could visit.

We saw one person who had difficulty eating due to a physical disability and their lunch had been left just within their reach but was not cut up for them and was not in a suitable position for eating. This meant that they spilled their dinner all over themselves and could not eat their meal properly or with dignity.

We tried to communicate with one person who used a communication aid. Their aid was covered in stains and encrusted food which was undignified for them as this was their only means of communication.

We saw seven people sitting in a lounge watching television. Six of the armchairs in this room had the cushions turned upwards. We asked a member of staff why this was and they responded by shrugging and saying they did not know but they may have been cleaned. They did not replace the cushions at that time. We tested several cushions and found them clean and dry. This gave the room a less homely feel and was not welcoming to anyone wishing to sit down. We also that there was one or two members of staff in the lounge at all times. However on two occasions we entered the room and found staff sitting or standing at the back of the room either talking to each other or watching over people. At these times we saw no attempt to sit with or interact with people who lived at the home.

A number of people who lived in the home told us that the home used a lot of staff for whom English was not their first language. They said these staff at times communicated with each other in their own languages whilst supporting people with their personal care. The people we spoke with found this disrespectful and undignified.

A number of concerns had also been raised with us about staff communication prior to our inspection. This had included concerns from health professionals who provided examples of times when staff had appeared to mis-understand a request.

Whilst walking around the home we saw a number of signs on people's bedroom doors and in their

bedroom that stated "THICKENED FLUID STAGE 2". This meant that people's dietary needs were displayed for others to see and the people were being identified by their needs which is not a dignified or respectful way to talk to people and is also a breach of their right to privacy.

Before the third day of our inspection we had received concerns about the amount of towels and sheets available in the home. We checked this and found that although there were sufficient supplies these were not always in a fit state to be used. For example we found two towels in the laundry room one of which had a hole in and both of which were threadbare. We found a further two towels in a similar condition stored in linen cupboards. The manager told us she had ordered new sheets and would order new towels. Minutes of a staff meeting recorded that the manager had asked staff to dispose of any stained or ripped linen, two members of staff we spoke with were aware of this instruction. However the fact that these had not been disposed of by staff shows an uncaring attitude towards the quality of the service people were receiving.

These were breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that staff treated people with respect and dignity at all times.

Inadequate

Is the service responsive?

Our findings

Comments we received from people about the care that they received were very mixed. Some people said that staff were very supportive but a number of people said very negative things. These included "The shortage of staff makes it difficult to get to the toilet when you want to go. You ask and ask but no one helps you" and "I'm fed up with all the different staff who don't speak English and can't understand you. I've complained and complained but nobody listens."

We had concerns raised prior to the inspection that people needs were not being met particularly in relation to their nursing care needs. We looked at the nursing care being provided and found that it fell below acceptable standards.

We looked at one person's wound care and found that their dressings had not been changed at the correct time intervals leaving them at risk from infection and preventing the wound from healing. The care plan stated that the wound should be photographed every week to show the development or healing of the wound. The wound had not been photographed for over three weeks. This meant that the person was at risk of harm due to poor care.

We looked at another person's wound care and found that the care plan was poor and did not fully describe the care that was needed. This wound had not been photographed at all despite the care plan saying it needed to be photographed weekly.

We saw that one person's care plan said they had diabetes and needed 'rescue' foods to be available to them at all times. These included Lucozade and dextrose tablets. We checked and found that none were available for them. This meant that the person was at significant risk from harm if their diabetes became unstable.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that people received safe and appropriate care according to their needs.

We saw that the complaints policy was displayed on the wall in the foyer of the home. We looked at the complaints file and saw that formal written complaints had been investigated and responded to. However, during the inspection we became aware of a large number of complaints people living at the home and their relatives had made that did not appear to have been recorded or responded to.

This included complaints being raised with the appointed manager or deputy regarding bedding not being changed for a month, call bells not being answered, people not being supported to the toilet in a timely manner, family not being informed of their relative being admitted to hospital, safeguarding concerns not being reported swiftly and a person's catheter bag not been emptied so that it back filled and the poor care put them at risk of further infection.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that all complaints were appropriately managed.

Inadequate

Is the service well-led?

Our findings

The home had a manager who was not yet registered with CQC.

Records relating to people's care were very poor and had not been appropriately checked, updated or monitored. The care plans did not reflect the care that people required. The care provided was not of an acceptable standard, leaving people at risk from harm when they did not receive safe care. The care file audits had failed to recognise the concerns we identified.

The building and equipment was not always safe and fit for use, placing people at risk from harm. The auditing processes in place had not identified all of the concerns that we found.

The staffing support was not adequate. Staff were not always able to provide the care that the people in the home needed to be safe. The manager and provider had failed to take appropriate action to rectify these issues.

A number of concerns and complaints had been verbally made to members of the management team by relatives. These had not been recorded and relatives felt they had not been acted upon in a satisfactory manner.

We could see from the minutes of a staff meeting that the management team had tried to address staff communicating in front of people living at the home in their own languages. However, this had been ineffective and was still continuing.

The home employed a manager and a deputy manager. Concerns were raised with us prior to the inspection by health professionals that the chain of management was unclear. We were told that the deputy manager appeared unsure of their role stating 'I think so' when asked if they were the deputy. We asked the manager about this and they told us that the deputy had been given the role by the provider. However when we looked at records of staff roles we saw that they were still listed as an administrator. Confusion around the management structure within the home could lead to information not being given to or acted upon by the correct person.

These examples are all breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because there were no systems or processes in the home to ensure that the service provided was safe, caring, responsive or well led.

During the seven day period between the first two days of inspection we raised our concerns with both the manager and the provider and following the inspection we requested that urgent action was taken to mitigate the immediate and extreme concerns. The manager and provider submitted an action plan that told us that emergency work was being undertaken. We referred the findings from this inspection to the local authority and to the CCG (Clinical Commissioning Group).

We returned to the home 16 days after the second day of inspection to check that the provider had commenced implementing the action plan they had given us.

CQC records showed that following the first day of the inspection the manager had commenced the process of applying to CQC to be considered as the registered manager of this home.
We found that changes had been made including the appointment of a clinical lead for six months to oversee the nursing care provided. We saw that the clinical lead was working supernumerary and was supported by a second registered nurse at all times. We could see that they had begun to make changes to how the home operated and put systems into place to ensure people received safe, effective, caring and well led care. This had included ensuring any wounds or ulcers were clearly recorded, including details of the care required and regular photographing and monitoring to ensure they were healing as expected. Work had commenced on care plans to ensure they contained easy to understand information to guide staff on the support the person required and how this was to be delivered.

We found that nurses were not working at the home unless they had the required skills to provide the care that people needed. Training had been booked in using a syringe driver, catheter care and end of life care to support staff with these skills. The home's action plan stated that staffing levels would be monitored and a dependency tool used. We saw that staffing levels were adequate on the third day of our inspection and a system had been introduced on the nursing unit to allocate staff to ensure they had breaks at different times and that sufficient staff were available to support people when needed.

Action had been taken to secure unsafe bedrooms and fit window restrictors where needed.

The systems we saw being implemented were new to the home, had not been fully implemented or tested and had not had sufficient time to become embedded. We were therefore unable to judge how effective they were or would be in the longer term at ensuring people received a consistent safe, effective, well led and caring service.