Idun Management Services Limited

Whitchurch Care Home

Inspection report

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Date of inspection visit:
24 October 2017

Date of publication:
04 January 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out a comprehensive inspection on 24 October 2017. The previous comprehensive inspection was undertaken in February 2017. At this inspection the provider had breached three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations. These breaches related to: safe care and treatment; good Governance and person-centred care. The service was rated as 'Requires Improvement'. Following the previous inspection in February 2017 the provider has been sending monthly reports regarding their medicines management, records and auditing systems. At this inspection we checked whether improvements had been made and the service was no longer acting in breach of the regulations.

You can read the report from our last comprehensive inspection, by selecting the 'All reports' link for Whitchurch Care Home, on our website at www.cqc.org.uk

Whitchurch Care Home is registered to provide accommodation for persons who require personal or nursing care for up to 50 people. The service cares for older people, some of whom are living with dementia. At the time of our inspection there were 35 people living in the service.

There was no register 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 current manager has submitted their registered manager's application to the Commission for consideration.

At our last inspection in February 2017 we found that improvements were needed to make sure medicines were managed safely. Although areas of this work required further development sufficient improvements had been made.

At our previous inspection the provider had not consistently protected people against the risk of poor or inappropriate care as accurate records were not being maintained. The provider has been sending monthly progress reports on this issue of concern. At this inspection we found sufficient progress had been made.

At our previous inspection we found that care plans were not sufficiently detailed to help staff provide personalised care based on current needs. They were not consistently written in conjunction with people or their representative. At this inspection we found improvements had been made but this area of their work required further development.

At our previous inspection the provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. At this inspection we found sufficient improvements had been made.

A range of recruitment checks had been carried out on staff to determine their suitability for work. Staffing

levels were maintained in accordance with the assessed dependency needs of the people who used the service. Staff were supported through a training supervision programme.

People were cared for in a safe and clean environment. Regular maintenance and equipment audits were undertaken. Where actions were required they are taken forward within a reasonable timescale and recorded in the maintenance log book.

People's rights were upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves.

People told us that they thought the staff were caring and they were treated with dignity and respect. Staff were knowledgeable about people and understood their needs and preferences.

Advanced care plans were in place. Staff had documented their conversations with people and their relatives about people's choices in relation to the care they wanted to receive towards the end of their lives.

Staff told us there had been "a lot of changes" recently, but in the main spoke positively about the new manager. Following the previous inspection a staff meeting was held to discuss the Commission's report and the actions required to move the service forward. Staff said they attended regular staff meetings and were aware of plans for improvement.

People and their relatives provided positive feedback about the new manager. People were encouraged to provide feedback on their experience of the service. Actions were taken in response to the feedback.

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.

Medicines were in the main managed safely. Issues identified during the inspection were immediately taken forward.

Staffing levels were maintained in accordance with the assessed dependency needs of the people who used the service.

A range of recruitment checks had been carried out on staff to determine their suitability for work.

Is the service effective?

Good

The service was effective.

Staff were supported through a training and supervision programme.

People's records were completed correctly and monitored to manage their health conditions.

People's rights were being upheld in line with the Mental Capacity Act (MCA) 2005.

Is the service caring?

Good

The service was caring.

People told us that they thought the staff were caring.

Staff were knowledgeable about people and understood their needs and preferences.

People's choices were documented in relation to the care they wanted to receive towards the end of their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not consistently written in conjunction with people or their representative. This is currently work in progress.

The provider had a system in place to receive and monitor any complaints.

Relatives were welcomed to the service and could visit people at times that were convenient to them.

Is the service well-led?

Good

The service was well-led.

Effective systems were in place to assess and monitor the quality and safety of the service provided. Actions were being taken where required.

Staff, people and their relatives provided positive feedback about the new manager.

People were encouraged to provide feedback on their experience of the service. Actions were taken in response to the feedback.

Whitchurch 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. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook an unannounced inspection on 24 October 2017. The inspection was conducted by two adult social care inspectors, a pharmacist inspector 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 intelligence we held internally about the service and received information from the clinical commissioning authority. We used also used information the provider sent us in the 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 improvements they plan to make.

During the inspection we spoke with nine people, nine members of staff, five visitors, one visiting health professional, a resident experience care specialist and the manager. We observed part of the medicine round and interactions between staff and people in the communal areas of the service. We looked at the medicine administration records (MAR's) in current use and two people's care topical application records and care records. We reviewed seven care plans and a sample of food and fluid charts. We also reviewed the provider's audits relating to the health, safety and welfare of people who use the service.

Good

Is the service safe?

Our findings

At our last inspection in February 2017 we found that improvements were needed to make sure medicines were looked after safely. This related to use of medicines taken 'when required' and those for end of life care. Although areas of this work required further development, we found sufficient improvements had been made.

When people were prescribed medicines to be used 'when required', additional information was available for staff to help them give these medicines in a safe and consistent way. The doctor had reviewed medicines prescribed for use in end of life care. This helped to ensure staff would use these medicines appropriately.

Staff took account of how and when people liked to take their medicines. One person self-administered their night time medicines, so they could chose when to take them. Staff supported another person to self-administer one of their medicines, allowing them to keep some independence taking the medicine. Staff had assessed that people were safe to self-administer their medicines.

Staff recorded when people had taken their medicines on printed medicines administration records (MAR). Staff regularly checked the records had been completed properly. This allowed them to identify any mistakes quickly and take action to address them; so people could be confident they would receive their medicines correctly. However, we saw that staff had not received the most recent blood test result for one person prescribed a medicine with a variable dose, so they could not confirm that the dose was still correct. This had not been identified by the checks in place. Staff took action to address this during the inspection.

Staff applied some creams and ointments as part of people's personal care. These preparations and records of their application were kept in people's rooms. We found staff had not recorded the use of some barrier creams, which were not on individual prescriptions. This meant it was more difficult to review their use and effectiveness.

Medicines were stored safely and securely. Staff checked and recorded the temperature of medicines storage areas and refrigerators to make sure they were safe for storing medicines.

In addition to the daily checks of the administration records, staff made regular checks of the use of medicines in the home We saw examples of two weekly checks. We also saw a check done in May 2017 by the home's pharmacy. This helped to ensure that people's medicines were looked after safely. The manager also checked records daily and told us they addressed any issues they found. However, they did not document these unless they were medicines errors. This meant it was more difficult to review trends and progress made. The manager agreed to take this forward.

People and their relatives told us they felt the service was safe. Comments included; "Yes I feel safe but you miss your home comforts"; "Yes I feel safe. Here you have someone around you. You've got your bell to press"; "I'm safer here than I was at home. I was always falling "; "I feel very safe here. They say always give us a shout if you need anything or want help"; and "It is a safe environment for him here."

Staffing levels were assessed by following the Care Home Equation for Safe Staffing (CHESS) dependency tool. Staffing rotas viewed demonstrated that staffing levels were maintained in accordance with the assessed dependency needs of the people who used the service. We observed call bells being responded in a timely manner and people receiving staff assistance when required. The majority of staff, people and their visitors provided positive feedback about the staffing levels. Comments included; "Staffing levels are better"; ""Yes, we've got enough staff"; "We've definitely got enough staff, unless somebody goes off sick"; "Staffing has improved. We have enough." We did receive some reservations about the staffing levels; ""Enough staff? There aren't always enough of them around. You see the same faces in the day but at night they're all different"; "I'm very fond of them. Sometimes they're very short staffed"; and "Staffing can be a bit light and then you wait a little longer. They do check first- see if it's urgent and then come back when they can."

Appropriate arrangements were in place for reporting and reviewing accidents and incidents. This included auditing all incidents to identify any particular trend or lessons to be learned. Accident and incident forms identified the nature of the incident, immediate actions taken and whether any further actions were required. One person was found on the floor in their room. They were seen by their GP. Their care plan and risk assessment was amended regarding a new agreed strategy with the person to mitigate future risks.

Care plans contained risk assessments for areas such as falls, mobility, skin integrity and malnutrition. The risk assessments had all been reviewed monthly and when risks were identified, the plans guided staff on how to reduce the risks. For example, one person had been assessed on admission as being at high risk of falling. The plan guided staff to ensure the person had their mobility aid close by, to provide supervision when walking or transferring and to ensure the call bell was close to hand. The person had not fallen since they moved to the service two months earlier. Some people needed staff to use equipment when moving them and in these cases the details of which hoist and which size sling to use were detailed within the plans.

Recruitment checks had been consistently carried out in accordance with the provider's recruitment checks policy. Records showed that a range of checks had been carried out on staff to determine their suitability for work. This included obtaining references and undertaking a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal background and whether they were barred from working with vulnerable adults. Where poor performance had been identified the manager followed the provider's disciplinary procedure. This ensured people remained safe at the service.

Staff had attended safeguarding training to protect people from harm and abuse. All of the staff we spoke with knew how to recognise signs of abuse and how to report concerns. Staff were also familiar with the term whistleblowing. This is a process for staff to raise concerns about potential malpractice at work. One member of staff told us; "I'm happy to report any concerns to the deputy or the manager, and I would keep going higher if I needed to."

People were cared for in a safe and clean environment. Staff knew how to protect people from the risk of infection. We saw that staff had access to personal protective equipment (PPE) such as aprons and gloves. One staff member said "We all us PPE; the manager makes sure we do." All rooms were well maintained, hygienic and odour free. The kitchen had a five star rating by the Food Standards Agency. A full time maintenance person was employed by the service. Regular maintenance and equipment audits relating to fire safety records, legionella, maintenance of safety equipment, gas safety, boilers, call systems, portable appliance testing (PAT) were undertaken. Where actions were required they are taken forward within a reasonable timescale and recorded in the maintenance log book.

Good

Is the service effective?

Our findings

At our previous inspection in February 2017, the provider had not consistently protected people against the risk of poor or inappropriate care as accurate records were not being maintained. We issued an enforcement notice, which directed the provider to send monthly progress reports on this concerning issue. We found, at this inspection, sufficient progress had been achieved.

When people were assessed as having a high risk of skin breakdown, the plans detailed how staff should prevent this from happening. For example, air mattresses were being used to relieve pressure and people were having their positions changed regularly. Position change charts showed that people's positions were changed in accordance with the care plan. Regular checks of air mattresses were carried out and all of the air mattresses we looked at were set correctly. Pressure relieving mattresses when set in accordance with the person's weight can help to prevent the development of pressure areas.

People's records were completed correctly and monitored to manage their health conditions. Some people were having their food and fluid intake monitored. All of the charts we looked at had been completed in full, and showed that people had had enough to eat and drink.

People's rights were upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. In people's care plans we saw information about their mental capacity and that Deprivation of Liberty Safeguards (DoLS) were being applied for. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely. Some staff members we spoke with did not know who was subject to a DoLS authorisation.

People's capacity to consent to the different aspects of their care had been assessed. When people lacked capacity to consent, best interest decisions had been made and these had been fully documented, they showed who had been involved in the decision and how it had been reached. We did note one exception when best interest decisions had been made for one person, which did not provide any details of how the person was supported to participate in the decision. The manager agreed to review this person's capacity assessments and consent agreements. We observed staff asking people for their consent prior to assisting them.

New staff undertook an induction and a provider prescribed mandatory training programme before starting to care for people on their own. Staff told us about the training they had received; this covered a variety of subjects such as moving and handling, infection control, dementia care, pressure ulcer care and basic life support. The training records demonstrated that staff mandatory training was up to date. Staff said they had access to training and development that enabled them to carry out their roles. Comments included: "We had some really good dementia training recently"; "I'm doing my NVQ Level 3 which the company are paying for"; "We've had a lot of training recently, such as catheterisation and a clinical skills update." People and their relatives felt competent staff members supported them. Comments included; "The nursing staff appear

competent"; and "They have got him eating and drinking again. They suggested he have liquid meds and he has come on leaps and bounds since then." Staff were now supported through a regular supervision and appraisal programme. Supervision is where staff meet one to one with their line manager .

People were supported to have enough to eat and drink. People's nutritional needs were assessed and weights were monitored. When people lost weight the care plans showed that advice was sought. For example, one person had lost weight, the GP had been informed and the person was prescribed supplements. Staff had informed the kitchen and the person was provided with a fortified diet. The care plan guided staff to "provide small but frequent portions of food" and the person's preferences in relation to what they liked to eat were documented. When people had been assessed as having a high risk of choking, advice was sought from SALT (speech and language therapist) and this guidance was documented within the care plans. One person had been seen by the SALT team during 2016. Staff had recently documented that the person ate better when having a puree diet rather than a textured diet and had referred the person again for SALT advice.

People had access to on-going healthcare. Records showed that people had been reviewed by the GP, chiropodist and the dementia practitioner. A visiting health professional told us that the service was meeting their patient's specialist needs. They were in regular contact with the service to ensure the person's needs continued to be met.

Good

Is the service caring?

Our findings

People told us that they thought the staff were caring. Comments included; "The staff are wonderful, very kind and caring"; "They are all very good to me. I am very fond of them"; "The staff are like family. They talk to me as often as they can"; "The cleaning lady brought me in a pen from home to do my puzzles"; and "Staff talk and smile." Visitors also provided numerous positive comments about the staff. They included; "As a home it seems quite good. He seems quite happy here"; "Everyone seems very friendly here"; "She looks a lot better since she's been here. She's got company now"; "Very caring lovely people" and "His emotional needs are met here. Staff know when he is down and will chat to him." People told us they were treated with dignity and respect especially during personal care. Staff always knocked on bedroom doors before they entered.

Staff we spoke with were knowledgeable about people and understood their needs and preferences. Comments included; "People get good care here. We treat people with respect, always have a chat and tell people what we're doing. The residents get lots of choice to"; "It's really important to give people options and choices. I know I like my makeup done for example, and one lady here likes wearing makeup too so I always offer to help her with it. It's the little things that create the bigger picture"; "We have a good connection with the residents"; and "We want to be our best for the residents". Staff also appeared to know family members and visitors well and greeted them in a friendly and welcoming manner on arrival. They environment was friendly and relaxed.

During lunch tables were well presented and attractive. There were fresh flower decorations on the table which were arranged by people during their activity session. Music was playing in the background. All staff interacted with people in a friendly, caring and compassionate manner. Staff used first names and treated everyone with respect. People were offered two main course and pudding options. Food smelt appetising and looked attractive. Staff encouraged people to eat independently and would offer assistance, if requested. If staff offered and people did not want their assistance their decision was respected. We observed people being assisted to eat in their bedroom. Staff sat by the bedside in a chair whilst maintaining good eye contact with the person. Staff chatted whilst they were assisting and did not rush people. One person left nearly all of her mashed main course and advised that they did not like it but did not want anything different. Later we observed they were eating peaches and custard. In the dining room the chef asked people how they were and asked them whether they like to participate in the cake decorating activity in the afternoon. The lunchtime service was very efficient and calm. Staff knew their roles and worked well as a team.

All rooms visited had been personalised with personal memorabilia, furniture, photos and pictures. One person had their own small fridge where they kept snacks and drinks brought in by their family members. Beds were well made and rooms were tidy. Several people told us they had chosen their own bedding, pillows and curtains.

Advanced care plans were in place. Staff had documented their conversations with people and their relatives about people's choices in relation to the care they wanted to receive towards the end of their lives.

This included whether people wanted to be admitted to hospital or remain at the service. A health professional told us that the service was suited to provide end of life care for their patient. A discussion was held with a nurse regarding the need to continue to respect the person's decisions regarding their daily treatment and symptom control. The person's end of life care planning was a collaborative approach with the person, health professional and the service.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we found that care plans were not sufficiently detailed to help staff provide personalised care based on current needs. They were not consistently written in conjunction with people or their representatives. At this inspection, we found some improvements had been made but further development was required. The manager told us that this was still "work in progress."

Care plans were more person centred. A "My Choices" document had been completed in full, which provided staff with information about people's lives prior to moving to the service and their preferences and routines. For example, in one person's hygiene plan their preferred time to get up was documented, along with how they liked to dress and how often they preferred to shave. When we checked this person's daily records we saw that the person had been shaved daily in line with their preferences. In another person's plan, their hygiene preferences listed the type of toiletries they liked to use.

Wound care plans were detailed and included the wound dressing regime and photographs of the wound. This meant that staff could see clearly if people's wounds were healing or not. One person had a wound on their toe and staff had sought advice from the chiropodist. This advice was detailed within the plan.

Plans in relation to people's emotional and psychological needs were detailed. For example, in one person's plan it was documented that they tended to display signs of distress at certain times of the day. The guidance for staff on how to relieve the distress was clear, such as "a change of scenery" or "talk about the past" and "read passages from the bible to (person's name)".

The service had just implemented the National Early Warning Score (NEWS). Early Warning Scores have been developed to facilitate early detection of deterioration by categorising a patient's severity of illness and prompting nursing staff to request a medical review at specific trigger points. All of the nurses said it was a useful tool and understood how it should be used.

However, care plans for people who had limited communication abilities were not as detailed. For example, in one person's plan it had been documented "unable to communicate his needs", but the guidance for staff was limited to "monitor for signs of illness, pain or distress". There was nothing documented to inform staff how they would know if the person was experiencing any of these.

Plans in relation to people's health needs were specific to people's needs. For example, diabetes care plans included the signs and symptoms of hypoglycaemia and included the actions staff should take if this occurred. However, we did note that the plan for one person with a catheter was limited. The person was prone to urinary tract infections but the plan did not detail the signs and symptoms of a urine infection for staff to observe for or provide guidance on steps to avoid this happening.

The care plans had all been reviewed monthly; however, there was little evidence of people and their representatives being involved in this process. Staff said this was currently not happening "formally", but that they thought it should be. The manager told us this work was in its preliminary stages and would be

taken forward.

Staff told us they had access to the care plans and from discussions, it was clear that the staff knew people's needs. Staff knew people well. They were able to give a lot of background information regarding likes and dislikes, nutritional needs and their personal care requirements. One member of staff told us; "[Person's name] has a shower, puts her dressing gown on and then returns to her room. [Person's name] likes water running down her and doesn't like to be touched. [Person's name] likes being washed in their bedroom and has a towel on their chair to sit on." Staff also seemed to know family members and visitors well and greeted them in a friendly and welcoming manner on arrival. This demonstrated people were not isolated from those people closest to them.

People had access to activities. There was a six day printed activity schedule in every bedroom specifically for that week. Activities included flower arranging, cake decorating, quizzes, games, fellowship and film sessions. We received mixed comments about the activities. Comments included; "I go down to the activities. I was always helping people before I came here so I enjoy that. I like to read and do puzzles. I used to love knitting. I would like to knit but there is no one to get me any wool and needles. I will ask my grand-daughter when she comes"; "The activities are not very good"; "I can't do anything but watch TV and do word searches. I don't know what to do with my hands. My family bring me in a TV paper and I work out what to watch"; and "I like the activities here. I win everything. They're going to ban me soon." A number of people stayed in their rooms either through choice or frailty. We asked the activities coordinator how they made sure everyone had some one-to-one time. They told us they slotted one-to-one visits "as and when" they could during the day. There were no specific therapies for people who remained in their rooms, such as music or sensory therapies. We were told they would just hold their hands and talk to them and perhaps play some music . Staff told us they visited people for a chat and would like to spend more one-to-one time with them. One person was visited by the activities coordinator to play cards and they enjoyed this activity.

The provider had systems in place to receive and monitor any complaints that were made. Since the previous inspection the service had received three formal complaints. Where issues of concern were identified they were taken forward and actioned, such as the provision of further staff training.

Good

Is the service well-led?

Our findings

At our previous inspection in February 2017 the provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. The provider has been sending monthly reports regarding medicines management, care planning and governance systems. At this inspection sufficient improvements had been made. The shortfalls identified at our previous inspection had in the main been addressed. Where areas of concern required further development the service was taking forward, such as person centred planning. To ensure continuous improvement the manager and regional manager conducted a number of audits such as; health and safety; infection control; care plans; training; dining experience and medicines. This has resulted in improvements in the level of service, such as staff receiving regular training and supervision; menus being up-dated; and a refurbishment programme being implemented.

Staff told us there had been "a lot of changes" recently, but in the main spoke positively about the new manager. Comments included; "You can talk to him, make suggestions and he's happy to listen to our ideas"; "He's very approachable and asks us for our ideas"; "He tells us what needs to be done and why. We can go to him and he listens". All staff said communication in general had improved amongst the team. There were some exceptions describing them as "patronising" and "passing the buck" to other people.

Following the previous inspection a staff meeting had been held to discuss the Commission's report and the actions required to move the service forward. Staff said they attended regular staff meetings and were aware of plans for improvement. They told us; "A lot of new things have been implemented, and in a few months it will all be fully in place"; and "Morale has been rocky, but we've worked hard to make it better. We feel ready for this inspection, we've improved a lot."

People were encouraged to provide feedback on their experience of the service. The service has a 'Quality of Life' programme. People have access to an electronic tablet in the service to provide their views. Comments from people, staff, relatives and visiting health professionals included; "Very nice staff"; "Very clean and staff are welcoming"; "Help and advice is always there whenever I need "; and "Documentation is being addressed and training for all care staff has been identified by the Home Manager who has asked our team to assist." A recent compliment stated; "I want to pass on my thanks to you and all the staff at the care home for all the loving care given to [person's name] through the four and a half years she was resident there. I really cannot fault the service the home gave her and it gave me great peace of mind about her condition with me living so far away from Whitchurch."

Feedback comments highlighted that people felt contented living at the service and staff treated them with respect. Resident meetings were now held regularly. At the most recent relatives and residents meeting issues discussed included; introducing the team and the vision; CQC report; care standards; staffing; food and maintenance of the home. Most people were aware who the manager was. They spoke highly of the manager and said he was very visible and approachable. Comments included; "He seems very nice. He comes round to see us"; "As a home it seems quite good "; and "The manger is visible and we have meetings occasionally."