Wilton House Limited

Wilton House Residential and Nursing Home

Inspection report

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Ratings

Is the service safe?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 13 October 2015 and was unannounced. At the last inspection on 05 March 2015 we found the service was meeting the required standards. We inspected Wilton House Residential and Nursing Home because we received information of concern that suggested people were not safe. This report only covers our findings in relation to the question, "Is the service safe and well led?"

Wilton House Residential and Nursing Home provides accommodation and nursing care for up to fifty-one people. At the time of our inspection 47 people lived at the home and the service had 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.

At this inspection we found the service to be in breach of Regulation 12, 13, 17 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not transferred using equipment or moving and handling practises in a manner that was safe, or in line with their mobility needs.

People were not protected by staff who knew how to identify and report issues relating to possible abuse.

Summary of findings

People were not protected from the risk of infection as there were areas of the home that required cleaning, equipment was dirty and stained and slings were shared when hoisting people.

Recruitment checks did not ensure that staff employed were of sufficiently good character.

There were not robust systems in place to monitor and mitigate the risks to people where risks to people's health and safety were identified.

Systems were not robustly in place to assess, monitor and improve the quality and safety of the services provided to people.

An injury to a person living at the service had been notified to the Health and Safety Executive but had not been notified to CQC without delay as required by the regulations.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement 

The service is not consistently safe

People were not supported to transfer, for example from their wheelchair to a comfy chair, in a manner that was safe and protected them from harm.

Incidents and injuries to people were not sufficiently investigated to ensure people were safe.

There were not effective measures in place to prevent the spread of infection.

There were not robust recruitment procedures in place.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

Systems were not robustly in place to assess, monitor and improve the quality and safety of the services provided to people.

Systems were not effective in assessing, monitoring and mitigating the risks relating to the health, safety and welfare of service users who may be at risk.

Notifiable incidents were not reported without delay.

Wilton House Residential and Nursing 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.

This inspection took place on 13 October 2015 and was unannounced. We planned to inspect one of the five key questions we ask about services, 'is the service safe?' This was because we received information that suggested people were not transferred in a safe manner, incidents of bruising were not always followed up, and people were not protected from the risk of infection. During the inspection however we found concerns relating to the management and governance of Wilton House so also looked at whether the service was well led.

During the inspection we spoke with four people who lived at the home, three relatives, four members of staff, the registered manager and a representative of the provider. We received feedback from social care professionals prior to the inspection. We viewed three people's support plans, and four staff files. We also looked at documents relating to management and monitoring of the service.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe at the home; however they also told us that when staff assisted people to transfer using hoisting equipment they were rushed. One person told us, "Sometimes I get nervous when they lift me because they do it so quick and it can be quite nerve racking." A second person told us, "The staff are a good bunch, but some of them are a bit rough."

Staff we spoke with told us they received training so they could hoist and transfer people safely. This training was part of a three day induction and covered theory modules and a practical assessment. The deputy manager told us that they along with three other staff members were, accredited to provide this training to care staff. They also told us that they regularly observed staff transferring people and took action if poor moving and handling was seen. They told us, "we observe on a daily basis and if we see poor moving and handling then we deal with it through supervision and more training." We asked them to recall a time when they had provided additional support to a staff member due to poor practise, they told us, "It was a very long time ago, and over two years at least I think."

We observed people being transferred using hoists and wheelchairs in two of the communal lounges prior to lunch, during and afterwards. We observed four separate occasions where people were transferred in an unsafe manner that placed the person, staff member and other people at risk of harm. For example, one person had been assessed as requiring transferring using a full hoist. The nurse in charge told us, "[Person] is not weight bearing, has stiff knee joints so cannot stand and was assessed by the nursing team as needing a full hoist." We observed staff used a stand aid hoist for this person prior to lunch. A stand aid hoist must only be used where the person is able to consistently and reliably bear weight through their legs and have sufficient upper body muscle strength. We were told by the nurse that this person did not meet these criteria. We also saw that whilst the person was using the stand aid hoist, a staff member was sent to their room to collect their wheelchair. This inevitably resulted in a delay whilst the person was using the hoist and placed them at greater risk of injury. Safer practice would ensure that prior to transferring a person staff would prepare for hoisting, ensuring they have all the equipment needed to hand.

We later observed a member of the activity staff pushing a person in a wheelchair. They were seen to push the person in the chair at a brisk pace. In addition to placing the person at risk of injury, they were seen passing the communal dining areas where other people using the service were walking to and from. When asked why they were pushing the chair at such speed, they replied that, "[Person] wanted to go for a cigarette, they get agitated and I thought they had already lit it."

Over the course of our inspection we observed four separate occasions where people were placed at risk of harm. We made the registered manager aware of each occasion and they arranged an external trainer to deliver training to the identified staff later that day. However, this was instigated because we had identified the concerns. It was clear on all four occasions that on-going supervision and training was not effective as senior members of staff, including the deputy manager were present when staff transferred people in an unsafe manner who did not intervene to correct staff.

Where people had sustained a fall that was unwitnessed staff assessed the person for injuries and where necessary referred them to the GP or falls clinic. For example in September 2015 one person experienced seven falls. All were unwitnessed by staff and the person's care record showed they were referred to the GP and given antibiotics for a possible infection and referred to the falls team for review. However, the mobility care plan had only been updated on the day of our inspection in response to our request for a copy of the care plan. This review had not considered the increase in falls over the previous two weeks, or had not considered measures to keep the person safe, such as increased monitoring or the use of a sensor mat to alert staff when they got out of bed.

A second person was noted through July to September to have multiple bruises to their chest. A record was made in the incident log and staff developed a bruising care plan. However, we were unable to see where staff had reassessed and investigated the possible cause of these bruises. When we spoke with the manager about how they had investigated these bruises they told us they had not. We saw from the person's care plan that they were unable to walk or mobilise independently. However, they had been assessed as requiring bed rails, without protective bumpers. There was no risk assessment that considered the risk of injury or entrapment within the rails, should the

Is the service safe?

person attempt to get out of bed. Staff had also not recorded in the accompanying assessment and review that they had considered and dismissed the least restrictive option that would minimise the risk of injury, such as a profiling bed, crash and sensor mats. When we spoke with staff about considering the least restrictive option for this person, and others on the unit they told us they had not.

On a second unit we saw three people in the communal lounge who all were seated in their wheelchairs using a lap belt. Only one on these people was unable to freely stand without staff assistance. We saw that people attempted to remove the lap belt buckle, however were unable to due to a lack of dexterity in their fingers. The nurse told us that one of these people was sat in the chair with the lap belt in place because they frequently leaned forward and were at risk of falling from the chair. We spoke with the Nurse about other options that they considered. They told us that they had not, and that using the lap belt was considered to be the least restrictive option. However, when we again spoke with the nurse, with the manager present, they said that they could seek to acquire a reclining chair that would prevent the person from falling. This demonstrated that alternative options were available, however had not been considered until prompted by the inspector. They said that the belts were only used as a short term measure for when they were transferred, however we observed that this person was in their wheelchair throughout the day with the lap belt firmly fixed. This meant that staff had not assessed the risks to service users of receiving the care or treatment when required and had not done all that was reasonably practicable to mitigate any such risks, meaning people were at risk of being restrained.

We looked at the equipment that staff used to transfer people and saw that the hoists were unclean and had splattering of liquids and dried foodstuff on the foot plates and arms. Some of the wheelchairs we looked at had staining to the seat pad and side arms. Slings used to hoist people were draped over the hoists. We asked staff if people had their own slings, some staff told us people did and others told us they did not. We asked the nurse in charge of the second floor unit how many people required hoisting. They told us at that time 19 people required a full hoist, however they had only seven slings and one sling used for assisting people on and off the toilet. The provider's representative told us that they had recently ordered a new batch of slings for people, and showed us an invoice. However, the invoice shown was for June and September 2014 and did not take account of people's individual size, weight and support needs or the current number of people living in the home. People were therefore hoisted using shared slings, which meant effective measures were not used to prevent the spread of infection and assist people in a hygienic manner.

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

We have referred our findings to the local authority safeguarding and commissioning teams.

Staff we spoke with told us they had received safeguarding adults training. One staff member was able to demonstrate to us their knowledge of safeguarding and explained comprehensively how they continually observe people looking for any potential signs of abuse. They told us, "We keep people safe by looking for signs that indicate people may be harmed, like bruising or them being sad, and will immediately tell the nurse or manager if we suspect something." However, of the four staff spoken with, two of these staff were unable to describe to us how they kept people safe from harm and abuse. We asked one staff member, who told us they had received training recently, to tell us about safeguarding and whistleblowing. When asked about reporting concerns and whistleblowing they said, "I am sorry, I don't remember." When we later looked at this person's training record we saw that safeguarding training had been assigned to them to complete, but at the time of our inspection they had not done so. They had been employed at the service for over five weeks, and worked unsupervised with people without previous employment history of providing care to people. This meant people were at risk of harm and or abuse, because not all staff providing care to people had received a sufficient induction to provide them with appropriate knowledge of how to keep people safe and identify abuse before it happens.

We looked at how incidents and injuries to people was monitored, reviewed and investigated. Monthly audits of falls, skins tears, injuries and bruising were recorded on a sheet and reviewed by the registered manager. We saw that where people sustained an injury that required treatment they were referred to an appropriate health professional such as GP or falls specialist. However, the registered manager had not reviewed the falls and injuries to ascertain patterns, themes or trends to enable them to identify where people may be at risk of falling frequently.

Requires improvement

Is the service safe?

For the September review, where the tool asked them to consider the frequency of falls they had recorded an 'X' to indicate none. This meant that the manager had not reviewed the incidents sufficiently to ensure that people were kept safe. For example on reviewing the September incidents and falls we found that 14 of 37 recorded accidents occurred on the night shift. Further investigation had not reviewed staffing levels to ensure sufficient numbers of care staff were deployed. The manager told us that they were in the process of developing a new audit tool that would specifically review patterns to enable them to identify themes and trends.

Where staff identified people had bruising following an unwitnessed fall, or when providing personal care, these had also been recorded in the accident record, and reviewed monthly. However, where the cause was unknown the manager had not assured themselves that the bruising was not related to poor moving and handling or other possible avoidable harm. For example, the accident summary recorded bruising to right wrist, arm and lower back, right hand and finger. The only recorded action for this person was to apply arnica as the cause was unknown. We noted numerous other examples of sites on people where unexplained bruising was noted, however this had not been considered or investigated. Where injuries were present and the cause of this was unknown, people were referred to the GP or falls team; however the registered manager had not informed the local authority safeguarding team.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment checks were not robust. We looked at the records of four members of staff and found that the manager had not checked and verified people's references. For example, one staff member was interviewed via the telephone whilst living abroad. An offer of employment was made to them and a reference form was sent to them for their two previous employers and one personal referee to complete. The references we looked at were all written in the same handwriting, and when we made the registered manager aware of this they were unable to tell us why this was. Later during the inspection once the manager had spoken with the employee, it transpired that they had translated the employer's comments onto the form, and the employer had signed this. However, the reference was not verified until after our inspection.

The manager told us that they found recruiting locally was becoming more difficult to attract carers to the home. They said they had recently held a recruitment open day, and no potential candidates had attended. They said in order to find care staff they were now recruiting in Romania, and provided live in accommodation to 16 carers. They said that providing the accommodation enabled them to attract staff, who then moved from abroad to live at Wilton House. We found that the manager had not conducted sufficiently robust criminal records checks. Enquiries had not been made in the person's country of origin regarding their character and the manager relied solely on a UK criminal records check. However, as this was completed when people moved to the UK to begin work, then the checks contained no information. In some cases this was because the employee had been living in staff accommodation at the care home for a period of days when the checks were applied for.

This meant that people were not protected from staff that may not have the required character to provide care to them safely.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

Our findings

The system in place to monitor the quality of the service that people received was not always effective.

The manager told us that they and the provider carried out a range of weekly and monthly audits in the home. They said that on a weekly basis they conducted reviews of medicines, pressure sores, call bell response times and bruising. They told us that on a monthly basis they carried out reviews in Infection control, medicines, health and safety, pressure ulcers, accidents, wheelchairs, mattresses bedrails, mobility equipment, water temperature; peg feeding, catheters and care planning. However, these audits were not effective at identifying areas for improvement. For example, a check of hoisting equipment noted these were clean; however we observed and showed the manager where hoists were engrained with food stuff and stains. The last infection control audit was completed in July 2015. The manager said it was the provider's policy to complete this monthly. This had been signed off as compliant in all areas, however we found carpets and walls required a clean and people were sharing slings which had not been identified. The system used to identify patterns and trends for people who had an accident or injury was not robustly reviewed and investigated where concerns were raised.

We asked the manager if they had developed a service improvement plan that identified key areas for improvement. They told us they did not. They told us they would introduce a robust system of governance that would assess, monitor and improve the quality and safety of the services provided. However at the time of our inspection this was not in place.

We found it difficult to elicit from records what training staff had completed, and the training matrix we looked at was incomplete. Through discussion with the manager they were unable to tell us who had completed training, as records of attendance on training courses were not available. This meant that due to a lack of monitoring neither us nor the manager could be sure staff had received sufficient training relevant to their role, or that it had been reviewed when required.

On completion of the inspection the manager provided us with a copy of an action plan that addressed the key issues we had raised with them. Where this plan addressed these concerns they had not identified these issues themselves through an effective system of governance and review to keep people safe and improve the quality of the service provided.

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

We became aware that in the previous month a person had sustained a fall and injury resulting in a fractured bone. The registered manager is required to send CQC a notification of this event as soon as practicable afterwards which they had not done. They had submitted a health and safety notification under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) but not a separate notification to CQC as required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Safe Care and Treatment** **Regulation 12 (1) (2) (a) (b) (e)** Staff had not assessed the risks to the health and safety of service users receiving care or treatment and had not sought to mitigate these risks by any reasonably practicable means. Staff did not use assist people to transfer in a safe manner that mitigated the risks of harm to people. Regulation 12 (1) (2) (h) People were not protected from the risk of infection due to unclean equipment and shared slings.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Safeguarding service users from abuse and improper treatment** **Regulation 13 (1) (2) (3)** Systems were not in place to investigate effectively upon becoming aware of, evidence of suspected abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Good Governance** **Regulation 17 (1) (2) (a) (b)**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Fit and proper persons employed** **Regulation 19 (1) (a) (b)** Recruitment checks were not in place to ensure staff were of good character and had the necessary skills to provide care.
	Systems were not in place to monitor, review and improve the quality of service people received and protect their health and welfare.