

Wilton House Limited

Wilton Lodge Residential Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The inspection took place on 7 and 13 February 2016 and was unannounced. At our last inspection on 26 February 2015, the service was found to be meeting the required standards in the areas we looked at. Wilton lodge had been rated as good in all five domains. However at this inspection we found the service had deteriorated. The manager had recognised the need for improvements and was committed to improving the service. Wilton Lodge Residential Home provides accommodation and personal care for up to 36 older people, some of whom have dementia. It does not provide nursing care. At the time of our inspection 34 people were staying at the home.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run. However the manager has started the registration process and this had been received at the time of the inspection.

Trained staff helped people to take their medicines at the right time. We found that prescribed creams were not always documented when applied and that the guidance for medicines given when required (PRN) was not detailed enough. Safe medicines practices were not always followed by staff when administering people`s medicines.

Accidents and incidents were documented but not always investigated to identify trends and patterns and to ensure people were kept safe.

Safe and effective recruitment practices were followed to help ensure that all staff were suitably qualified and experienced. However we found that written and verbal communication skills some staff had needed improvement.

Care was not always provided in a way that promoted people's dignity and respected their privacy.

Staff obtained people's consent before providing personal care and support, they developed positive and caring relationships with the people they cared for and knew them well. However we found that the Mental Capacity Act principles were not always followed.

Complaints were recorded and responded to in line with the service's policy. People, relatives and staff were complimentary about the manager and how the home was run. However we found that audits did not identify shortfalls or areas of concern and had not led to the necessary improvements being made.

People were not always supported to pursue social interests and take part in meaningful activities relevant to their needs, both at the home and in the wider community.

People felt safe, happy and well looked after at the home. Staff had received training in how to safeguard people from abuse and knew how to report concerns, both internally and externally.

People received personalised care and support which took account of their preferences. Staff were knowledgeable about people's background histories, preferences, routines and personal circumstances, however the environment was not designed to promote the wellbeing of people living with dementia.

Plans and guidance had been drawn up to help staff deal with unforeseen events and emergencies. The environment and equipment used were regularly checked and well maintained to keep people safe.

People and relatives were positive about the skills, experience and abilities of staff who worked at the home. They received training and refresher updates relevant to their roles and had regular supervision meetings to discuss and review their development and performance.

People were supported to access health and social care professionals when necessary. They were provided with a healthy balanced diet that met their individual needs.

People were involved in the planning, delivery and reviews of the care and support provided. The confidentiality of information held about their medical and personal histories was securely maintained throughout the home.

Complaints were recorded and responded to in line with the service policy. People, relatives and staff were complimentary about the manager and how the home was run and operated. However we found that audits had no systems in place to ensure areas identified were improved.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

People were not always supported to take their medicines safely by trained staff.

Accidents and incidents were not always investigated to keep people safe.

People were kept safe by staff trained to recognise and respond effectively to the risks of abuse.

Safe and effective recruitment practices were followed to help ensure that all staff were fit, able and qualified to do their jobs.

Sufficient numbers of staff were available to meet people's individual needs at all times.

Requires Improvement ●

Is the service effective?

The service was not always effective.

People had their capacity assessed and best interest decisions were not always made following best interest processes in line with the MCA principles.

The environment was not dementia friendly.

People's wishes and consent were obtained by staff before care and support was provided.

People were supported by staff that were trained to meet people's needs effectively.

People were provided with a healthy balanced diet which met their needs.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Care was provided in a way that did not always promote people's

Requires Improvement ●

dignity and respected their privacy.

People were cared for by staff who knew them well and were familiar with their needs.

People and their relatives were involved in the planning, delivery and reviews of the care and support provided.

People's confidentiality of personal information had been maintained.

Is the service responsive?

The service was not always responsive.

Care plans we looked at were not always person centred or have good guidance for staff.

People were not supported to follow their interests and access the community when they wanted.

People received personalised care that took account of their preferences and personal circumstances.

People and their relatives were confident to raise concerns which were dealt with promptly.

Requires Improvement ●

Is the service well-led?

The service was not always well led.

Systems in place to quality assure the services provided, manage risks and drive improvement were not effective.

People and staff were very positive about the manager and how the home operated.

Staff understood their roles and responsibilities and felt well supported by the management team.

Requires Improvement ●

Wilton Lodge Residential 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection was carried out on 07 February 2016 by two Inspectors and one expert by experience. An expert by experience is a person who has experience in this type of service. This was to help facilitate the inspection and make sure that people who used the service and staff members were able to talk with us. On 13 February we held a telephone interview with the manager who could not be present in the home on the day of the inspection.

The inspection was unannounced. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that requires them to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed, information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with seven people who lived at the home, four relatives, five staff members, the manager, deputy manager, general manager and the community nurse. We looked at care plans relating to three people and three staff files and a range of other relevant documents relating to how the service operated. These included monitoring data, training records, complaints and compliments.

Is the service safe?

Our findings

People were supported to take their medicines by staff that were properly trained and had their competency assessed. There were suitable arrangements for the safe storage, management and disposal of medicines. However we found that where people had been prescribed creams records to show that creams were being applied as prescribed were not consistently completed and some people did not have any records to show creams being applied. The manager told us they were aware of this and they were planning to introduce new charts to improve this.

We found that where medicines were prescribed to be given when required, for example for pain relief, there was little guidance for staff on when to give these especially for people who were not able to communicate their needs verbally.

We observed that staff had not always followed safe practices when administering people`s medicines. For example at lunch time one staff member was observed leaving the person's medicine on the dining table for them to take. There were other people seated at the table however the staff member was observed dispensing medicines to other people. They had not stayed to observe the medicine had been taken safely. This was not a safe practice because the medicines could have been taken by other people and placed them at risk of ill health.

Information gathered in relation to accidents and incidents that had occurred had been documented by staff. However, when we looked at the accidents and incidents logs we found that this had not triggered further investigations to ensure people were safe. For example, we found that one person had several falls in a month period and two falls occurred on the same day. The person told us that they had fallen a few times and that this really scared them. We found that no further investigations had occurred to identify why the person had fallen or measures put in place to reduce the risk of further incidents. The manager was not aware that the person had multiple falls and agreed that monitoring needed to improve.

The lack of accountability for prescribed creams and as required medicines and the poor monitoring of incidents and accidents was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People who lived at the home told us they felt safe. One person told us, "Oh yes I am completely safe here and I am very happy as well, all the staff are lovely and I get my medication on time." One relative said, "We are very happy with things here and we believe that [Relative] is very safe." Staff we spoke with were able to verbally demonstrate they could recognise signs of abuse and understood how to report any concerns they had. One staff member said, "I need to inform my manager about any concerns". Staff told us they kept people safe by regularly making sure equipment people used was safe and that areas were kept clutter free to prevent people from trip hazards. Staff also were able to demonstrate they could escalate their concerns if required.

However we found that potential concerns were not always identified and responded to keep people safe.

For example staff documented unexplained bruising for one person on three occasions and for another person on one occasion. There had been no investigation or explanation to how these bruises had occurred and these had not been reported to the local safeguarding authorities for further investigation. The manager checked and found no follow up had taken place to ensure there were no on-going risks to people. This meant that potential abuse may not be identified or responded to in line with locally agreed procedures.

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

Safe and effective recruitment practices were followed to help ensure that all staff were of good character, and fit for the roles they performed. All staff had been through recruitment procedures which involved obtaining satisfactory references and background checks with the Disclosure and Barring Service (DBS) before they were employed by the service. Staff also where required had an English assessment to ensure they had good written and verbal communication skills. However we found that some staff`s written and verbal communication was not good. For example when we asked staff questions during the inspection we found that some staff did not always understand what we were asking. The manager explained that they offered support to staff, however staff had not taken the opportunities to develop their written and verbal communication skills. One person told us, "I like all the staff, they are very helpful, sometimes there is a language barrier as most of them are foreign but we do manage to understand each other."

People told us there were enough suitably experienced, skilled and qualified staff available to meet people's needs safely and effectively. However the manager had recognised that there needed to be an increase in the night staffing levels to ensure people's changing needs were met. We noted in January during a staff meeting that night staff had requested extra night staff. The manager confirmed that an extra night shift was to be implemented after the inspection. Staff felt there was enough staff to meet people's needs. One staff member said, "I feel there is enough staff." Another staff member said, "It can be a problem when people cancel their shift and agency is used, if we have full staffing its ok."

Plans and guidance were available to help staff deal with unforeseen events and emergencies which included relevant training such as first aid and fire safety. Regular checks were carried out to ensure that both the environment and the equipment used were well maintained to keep people safe. For example, the fire alarm systems were regularly tested. Staff we spoke with confirmed there had been fire drills.

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA and found that they were not.

For example we found one person who had been assessed as not having capacity to understand their care needs. They had a best interest decision made about their care. This had been completed by the keyworker and had not involved other relevant people in the person's life such as their family members or health and social care professionals. We found that another person's care plan stated that family members had given consent for the care the person received, however there was no evidence that the relatives had power of attorney for care and welfare and this had not been investigated further to ensure that they were able to give consent in behalf of their family member.

Staff we spoke with were not always able to demonstrate that they understood the Mental Capacity Act. However they told us that they understood the importance of ensuring people gave their consent to the care and support they received. One staff member said, "We explain all the tasks we are doing. We involve the person; we are offering choice all the time."

Many of the people who lived at Wilton Lodge were living with dementia. The home had two floors and the manager confirmed that the first floor accommodated people who lived with dementia. However we found that people with dementia lived on the ground floor as well. We found that the environment, particularly on the ground floor, was not orientated to support a better experience for people who lived with dementia. For example, there were no points of interest for people to enjoy when walking about. The manager had recently had some chairs placed in different part of the home for people to stop and sit. We also noted in a meeting in November the manager talked about changing the seating areas to create a more intimate and sociable environment. The manager confirmed that there were plans to brighten up corridors and interior decoration. There were plans to create themed sections on walls and some tactile areas to improve people's experience.

People were supported to eat healthy meals and had their likes and dislikes noted in their support plans. People were asked daily what they wanted to choose from the menu or alternatives were offered if they wanted. We spoke with the chef who showed us the system they used in the kitchen that supported people's dietary needs. We saw there were lists of people's dietary requirements and this included likes, dislikes and allergies to ensure people were safe. One person said, "The food is lovely and we get choice, they cook us what we want, I have no complaints about the food."

Staff completed an induction programme, during which they received training relevant to their roles, and

had their competencies observed and assessed in the work place. Staff received the provider's mandatory training and regular updates in a range of subjects designed to help them perform their roles effectively. This included areas such as moving and handling, medicines and infection control. One staff member said, "I had an induction and the last training I completed was end of life training." Another staff member said, "I had to read the policies on my induction. I had shadowing for a couple of days (Shadowing is when the staff member works alongside a competent member of staff until they are competent to work independently). I felt supported, everyone wanted to help me."

Staff felt supported by the manager and deputy manager, they were actively encouraged to have their say about any concerns they had in how the service operated. Staff attended regular meetings and discussed issues that were important to them. They also had regular supervisions where their performance and development were reviewed. A staff member commented, "We have supervisions with the deputy manager, we have meetings. We talk about any issues and the residents. I am listened to." They also confirmed that the manager`s door was always open and they could see them at any time to discuss any issues. Another staff member commented, "We get regular supervisions here and we are supported to do all our training."

People received care, treatment and support which promoted their health and welfare. One person commented, "Staff will get a doctor if I need one." People had access to GP's and other care professionals when required. We saw that this had been recorded in people`s care plans. One community professional commented that they were happy with the care people received.

Is the service caring?

Our findings

People were cared for and supported by staff that knew them well and were familiar with their needs. One person told us, "Oh yes the staff are very caring and respectful, they treat me with dignity too." A relative said, "Yes the staff are very nice and do care about the residents here, staff are wonderful and they do try their best."

Staff told us how they promoted people's dignity and respect by closing doors and having good communication with people. We saw staff knocking on people's doors before entering. Staff had positive and caring relationships with people they supported and were knowledgeable about their individual needs and preferences. One staff member we spoke with was able to tell us about one person's likes and dislikes and knew about the person's allergies and the medicine the person was taking. One person said, "The staff are absolutely marvellous here, yes they know me well and look after me. They are very polite and really do care I am very happy. One staff member said, "I always knock on doors and say good morning. It's important to respect people's privacy."

However we saw examples of where staff did not always respect people's dignity. For example at lunch time we saw one staff member encouraging a person to eat their lunch. This was done in a way that did not promote their dignity. Another staff member was speaking loudly to a person across a dining table about their medicines and the person stated they did not want to talk about it. We pointed out to one staff member that a person's slipper was not on properly. The staff member bent down and moved the person's leg and secured the slipper. This was done without explaining to the person what they were doing and they did not promote their independence by encouraging them to secure their own slipper by themselves.

We saw one person being supported to move with a hoist. Staff used a privacy screen but the person was still visible to other people sat behind the screen. We noted that staff did not explain to the person what they were doing or give reassurance. Whilst being hoisted the person's trousers fell down and staff were slow to notice and react. Staff were prompted by another person living in the home that the person was losing their trousers. A relative commented, "The majority of the staff are very good but they need to be trained on interaction and social skills."

We saw that staff had developed relationships with people they supported. People and their relatives where appropriate had been fully involved in the planning and review of the care and support provided. One person said, "I am involved in my care plan." One relative commented, "We are invited to reviews and we make sure that [Relative] needs are being met."

Confidentiality was well maintained throughout the home and information held about people's health, support needs and medical histories was kept secure. Information about advocacy services was made available to people and their relatives should this be required.

Is the service responsive?

Our findings

People received personalised care and support that met their individual needs. One person said, "Yes I am involved in my care and staff do listen to me. I get everything I need here." A relative commented, "Yes my [Relative] is involved in all the care plans for my [Relative] we feel staff know them well and they are responsive to us and they did fix up the pathway and lightning when we pointed out the danger."

Not all care plans were personalised or captured all the details that mattered to that person. For example, their likes and dislikes, individual cultural and religious needs. Care plan contains some contradictory information and did not always give sufficient guidance to staff about how to meet people's needs. For example for one person who required two staff for transfers the care plan stated that the mobility aids used should be fit for purpose and staff trained to use them however it did not state what aids were used. The same care plan stated, `Ensure continence management routine is effective`. There was no detail of what this meant for that person. We noted the person had been identified being at risk of chronic constipation; however there were no details on how this should be prevented. We also noted that the person showed an increase in weight from 70.6kg to 85 kg since November 2016 but no note of any investigation or explanation about why this happened.

People were not always supported to maintain their interests and take part in meaningful activities. The activities coordinator told us, "I have a budget for activities and would like more money to do more things with them [people] as it would really benefit the residents, we do chair bowling, games, play cards, have live singer coming in. I need to keep them stimulated a lot, and we do Easter egg crafts and Christmas crafts." We saw activities in the lounge, on the ground floor during the day. However this did not always involve everyone. One person told us, "I do get bored though day in day out. I wish I could go out in the community more."

In the afternoon we observed the first floor lounge where twelve people sat looking at the television. The sound was on low and no one was watching the programme, two staff walked around but did very little to engage or socialise with the people who appeared bored. One person told us they wanted to go out but were not able to without support. They explained they felt, `locked in`. They told us that this wasn't what they wanted at their age. They couldn't wait to visit a library to get a book to read and that they wished to have a newspaper to read. This meant not all people who lived at Wilton Lodge were supported to have their social needs met.

We noted from a meeting held to discuss the activities in November the manager had identified the lack of meaningful activities. There were plans to develop the activities and the manager confirmed this was part of their service development plan.

People and their relatives told us they were consulted and updated about the services provided. They felt listened to and told us that staff and the management responded to any complaints or concerns raised. One person told us, "I know who to complain to and at the moment I have no concerns. One relative told us, "I have put in a formal complaint and it was dealt with but I am still not happy about everything." Another

relative commented, "We have raised concerns in the past and they have dealt with them so yes I believe things are okay here." We saw in a recent residents meeting the manager had asked people if they knew who to speak to should they had any complaints. We saw where complaints had been received these were responded to in line with the service complaints procedure. We also noted that people had sent in compliment letters thanking the staff for the care and support provided.

Is the service well-led?

Our findings

Audits were carried out in areas such as medicines, infection control, care planning and record keeping. There were monthly audits completed by managers to check if the care and support people received followed best practice. Where issues were identified, these had been documented but we found there were no systems in place to ensure areas identified were improved. For example, the general manager's monthly compliance visits in November and December 2016 noted that unexplained bruises needed to be investigated and documented with findings and actions. However we found that where people had been found with unexplained bruises no investigation had taken place. We found that identified areas for improvement did not have an action plan with a date for completion. For example we found one care plan audit that stated: Care plans needs updating. We saw this written against a few care plans but it did not state what part of the care plan required updating, by whom and by when and it was not clear if any of the changes had been completed.

The manager was not always knowledgeable about the people who used the service, their different needs, personal circumstances and relationships. For example we identified one person who had several falls and the manager had not been aware of this. No action had been taken to look into the possible reasons for the falls or to take action to reduce any on-going risks.

The ineffective quality monitoring was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People who stayed at the Wilton Lodge, their relatives and staff were all positive about how the home was run. They were complimentary about the manager and deputy manager who were described as being approachable and supportive. One person said, "Yes I know the manager and the deputy manager is always here. I feel they are doing their best here for all us people." One relative said, "I know the manager as we have had problems, they haven't been here long so there are some improvements to be made with some of the staff." One staff member said, "The deputy manager is very supportive." The manager told us they had an open door policy.

Staff understood their roles; they were clear about their responsibilities and what was expected of them. A staff member commented, "We have good team work, good place to work, good care here."

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The manager had informed the CQC of significant events.

The manager was clear about their vision regarding the purpose of the home, how it operated and the level of care provided. They told us they completed regular walks around the home; they talked to people and checked everything was alright. They observed and checked staff competencies and staff knowledge. They ensured the environment was safe. However we observed that the environment was not tailored to suit the needs of people living with dementia. Staff we spoke with confirmed the manager was visible around the home. After the inspection the manager sent a list of the improvements they were planning for the home. These included, improving the environment to better meet the needs of people living with dementia and

opening a shop in the reception area. They also had plans for more outside trips and creating life story books to make people's experience more person centred.

The manager received support from their general manager and operations manager and they had regular meetings to support learning. The manager said, "I feel supported and I have recently had supervision." The manager told us they started in November 2016 and have highlighted lots of issues in the home for example communication was poor and some staff struggled to understand what was being said. They also commented that management were very good and supportive. We found that during the inspection the manager was not always knowledgeable of all the details and information we requested. However they were supported by the deputy manager who had worked in the home for a longer period of time.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12(2)(a) Assessing the risks to the health and safety of service users 12 (2)(g) Proper and safe management of medicines
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment 13(2) Systems and processes must be established and operated effectively to prevent abuse of service users.
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17(2)(b) Assess, monitor and mitigate the risks relating to the health and safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.