Croftwood Care UK Limited

Whetstone Hey Residential Care Home

Inspection report

Old Chester Road
Great Sutton
Ellesmere Port
Merseyside
CH66 3JX

Tel: 01513396233
Website: www.minstercaregroup.co.uk

Date of inspection visit:
18 April 2018
23 April 2018

Date of publication:
11 June 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 18 and 23 April 2018. It was the first inspection of the service since a change of registration in November 2017.

Whetstone Hey is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home accommodates up to 42 people in purpose-built premises. The home does not provide nursing care.

The home is required to have 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. A new manager had been appointed in January 2018 and had started the process for registration with CQC.

People we spoke with believed the home was safe. Maintenance records showed that regular checks of services and equipment were carried out by the home's maintenance person and testing, servicing and maintenance of utilities and equipment was carried out as required by external contractors.

The home had a manager, deputy manager, care team leaders, senior carers and care assistants. There was a care team leader on every shift and during the day there was also a senior carer. This ensured there was a senior person who was able to administer medication on each floor.

Ancillary staff covered cleaning, laundry and kitchen duties. They were managed by the home services manager and there was also a domestic supervisor who people spoke highly of. All parts of the premises looked clean. The home had received an excellent score following an infection control inspection in February 2018 and the kitchen had a five star food hygiene rating.

We looked at the recruitment records for three members of staff who started working at the home recently. Records showed that robust recruitment procedures had been followed to ensure staff were of good character.

We looked at the arrangements for people's medication. We found that, in general, medicines were stored and handled safely, however there were some areas for improvement. Hand-written entries on MAR sheets had not been signed. These should be double signed, first by the member of staff making the entry, and second by another member of staff who has checked that it is correct. Prescribed creams and ointments were only signed for occasionally and this did not show they had been applied consistently as prescribed.

Risk assessments were recorded in people's care notes but effective plans were not always in place to reduce the risks identified. A log of accidents and incidents was maintained and the records showed that

appropriate action had been taken when accidents occurred.

Staff received training about safeguarding as part of their induction, with updates periodically. We spoke with staff who said they would have no hesitation in reporting any concerns. The manager had reported safeguarding incidents as required and full records were kept of safeguarding referrals that had been made.

The previous manager had made appropriate DoLS applications to the local authority. Some of these had been authorised but others were still awaiting consideration.

People could choose where they wanted to eat and who they sat with. The cook was aware of people's preferences and told us they always made an alternative for people who did not want to have the meals on the menu. People told us they enjoyed their meals and had plenty to eat and drink.

There was a programme of on-line training for all staff to ensure that they knew how to work safely. This was supplemented by practical moving and handling, fire safety and first aid training. The manager told us all of the care staff were required to complete the Care Certificate.

People who lived at the home told us that the staff provided them with good care and support. One person commented "I love it here." Another person said "It's marvellous." Everyone had their own bedroom and personal care was provided in a discreet way in the privacy of the person's room. There was a sense of community within the home and one person who had lived there for a number of years told us "The staff are like my second family. They are all good to me from the cleaners to the higher ups."

People's personal information was kept securely in offices that were locked when unoccupied and this protected their confidentiality. We also noted the use of room numbers rather than names on files to protect confidentiality.

The care files we looked at showed that people's care and support needs were assessed covering all aspects of their health and personal care needs. The assessments fed into a lengthy document called 'My Health Needs'.

There was no planned programme of regular social activities. The manager told us that the home had been without an activities organiser for the last few weeks but two part-time activities organisers had now been appointed.

The home's complaints procedure was displayed and people we spoke with said they would tell the manager or another member of staff if they had any complaints.

We saw evidence of regular staff meetings which were well attended. The minutes of the staff meetings showed that staff felt able to express their views. People living at the home told us they attended resident meetings and records showed that these were held regularly.

There was a schedule of quality audits for the year and these had all been completed to date. We looked at the records and found evidence of regular checks of care plans, kitchen hygiene, meals, laundry, medication, infection control, health and safety, maintenance and gardens and finance. These were accompanied by action plans for improvement as needed.

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 was mainly safe.

In general, people's medicines were stored and handled safely, however there were some areas for improvement.

Robust recruitment procedures had been followed to ensure that new staff were of good character.

Regular checks of services and equipment were carried out. All parts of the premises looked clean and the home had a very good infection control rating.

Is the service effective?

Requires Improvement

The service was mainly effective.

Appropriate DoLS applications had been made to the local authority. There was a lack of information about people's capacity to make specific decisions and limited evidence of consent being obtained.

People had a choice of meals and malnutrition risk assessments were completed monthly. Food monitoring charts were not always completed consistently.

Staff received regular training and supervision to ensure they knew how to work safely and effectively.

Is the service caring?

Good

The service was caring.

People told us that the staff provided them with good care and support and we observed that staff protected people's dignity and individuality by respecting their choices and preferences.

People were encouraged to be independent and pursue their interests.

People's personal information was kept securely to protect their confidentiality.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care and support needs were assessed and the care files we looked at showed that people had access to health professionals as needed.

There had been a lack of organised social activities in recent weeks.

The home's complaints procedure was displayed.

Is the service well-led?

Good

The service was well led.

The home had a new manager who had started the process for registration with CQC.

Regular meetings were held for staff and for people living at the home.

The manager completed a series of quality audits which were accompanied by action plans for improvement as needed.

Whetstone Hey Residential 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 visited the service on 18 and 23 April 2018. The inspection was unannounced and was carried out by an adult social care inspector.

Before our inspection we looked at the information CQC had received about the service including notifications of incidents that the provider had sent us, complaints and safeguarding. We read the report from Healthwatch Cheshire West following their visit to the home in February 2018, and information received from the local authority.

During our visit to the service we spoke with five people who used the service, two visitors and seven members of staff including the manager and the deputy manager.

We observed care and support in communal areas and staff interaction with people. We looked at people's care records and records relating to health and safety, staff, and the management of the service.

Requires Improvement

Is the service safe?

Our findings

People we spoke with believed the home was safe. One person told us "I know I'm absolutely safe here." We looked at maintenance records which showed that regular checks of services and equipment were carried out by the home's maintenance person. Records showed that testing, servicing and maintenance of utilities and equipment was carried out as required by external contractors. However, the manager was unable to find records of recent Legionella testing and the home services manager said they would follow this up.

Automatic closers were fitted to bedroom and corridor doors so that they would close in the event of fire. A fire risk assessment was in place and had had been kept under review. Fire evacuation equipment was available on staircases. Regular fire drills were recorded and there was a personal emergency evacuation plan for each person living at the home. A weekly fire alarm test was carried out and recorded. The week before this inspection there had been a potential fire in an electrical cupboard. The fire alarm activated and smoke was present. Evacuation procedures had been followed and the manager and staff had been commended for their actions.

The home had a manager, deputy manager, care team leaders, senior carers and care assistants. There was a care team leader on every shift and during the day there was also a senior carer. This ensured there was a senior person who was able to administer medication on each floor.

The manager had identified that the number of staff on duty at night needed to increase from two to three and recruitment was taking place to cover this. At the time of this inspection there were three members of staff on duty some nights, but only two on other nights. The manager told us that Agencies were not always able to provide staff to cover. We found no evidence that this was putting people at high risk. The day staff were on duty until 10pm and there was currently nobody with significantly high care needs.

Ancillary staff covered cleaning, laundry and kitchen duties. They were managed by the home services manager and there was also a domestic supervisor who people spoke highly of. There were at least two domestic staff on duty each day along with a laundry assistant. Disposable gloves and aprons were available for staff to use when providing personal care. All parts of the premises looked clean. The home had received an excellent score following an infection control inspection in February 2018 and the kitchen had a five star food hygiene rating.

We looked at the recruitment records for three members of staff who started working at the home recently. Records showed that robust recruitment procedures had been followed to ensure staff were of good character.

We looked at the arrangements for people's medication. We found that, in general, medicines were stored and handled safely, however there were some areas for improvement. Medication was only handled by senior staff who had completed training and competency assessments. There was locked medication storage which was clean and tidy with minimal stock. There was a cabinet for the safe storage of controlled drugs. Room and fridge temperatures were recorded daily and showed that medicines were stored at safe

temperatures.

Monthly repeat medicines were checked in and signed for on the medication administration record (MAR) sheets. However, hand-written entries that were made on the MAR sheets had not been signed. These should be double signed, first by the member of staff making the entry, and second by another member of staff who has checked that it is correct.

Administration was unhurried and where appropriate, people were asked if they would like pain relief medication. Administration records were well completed with coding used to explain any medication that had not been given. However, prescribed creams and ointments were only signed for occasionally and this did not show they had been applied consistently as prescribed.

Risk assessments were recorded in people's care notes but effective plans were not always in place to reduce the risks identified. For example, one person who was living with dementia had been identified as being at high risk of falls and the action to reduce the risk was for the person to take care when mobilising. We also found some inconsistencies in the records, for example one person was scored as high risk for falls, skin integrity and nutrition, however the person's dependency score was recorded as 'low'.

A log of accidents and incidents was maintained and the records showed that appropriate action had been taken when accidents occurred, for example referral to the falls prevention team and use of technology. The manager had informed CQC of serious incidents that occurred. However, accident reports were not analysed to find out if there are any trends, for example the time of day when accidents occurred or the part of the building they had happened in.

Staff received training about safeguarding as part of their induction, with updates periodically. We spoke with staff who said they would have no hesitation in reporting any concerns. Contact information was available for them in the staff office. CQC records showed that the manager had reported safeguarding incidents as required and full records were kept of safeguarding referrals that had been made. A safeguarding incident occurring in February 2018 had been investigated by local authority and confirmed that appropriate action had been taken.

Requires Improvement

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The previous manager had made appropriate DoLS applications to the local authority. Some of these had been authorised but others were still awaiting consideration. The deputy manager told us they were having difficulty in fulfilling the conditions applied to one of the DoLS and a best interests meeting was held on the second day of our visit to decide a way forward for the person to ensure they could be supported appropriately.

We saw completed consent forms in people's care notes. One consent form referred to the name of a different service. One consent form had been signed by a person who had been assessed as lacking mental capacity to make decisions so it was unclear whether they had understood the document they were signing. We found a lack of information in the care files about people's capacity to make specific decisions and the daily records did not show evidence of consent being obtained by care staff before support was provided. However, the large majority of people living at the home were perfectly able to make and express their own decisions.

We also found no records of any Power of Attorney arrangements that were in place. It is good practice for the home to keep a record of any Power of Attorney arrangements so that they are aware of the people legally responsible for making decisions on behalf of a person if needed.

We recommend that staff should receive further training regarding consent to ensure that they have a fuller understanding of the processes involved in obtaining consent.

The home had three dining rooms, one large room on the ground floor and two smaller rooms on the first floor. People could choose where they wanted to eat and who they sat with. The dining rooms were set for meals with tablecloths, cutlery, glasses and menus detailing the week's choices. We observed that people sat at the table for breakfast and lunch and made it a social occasion. Others had meals in their own rooms. Lunch was a light meal and the main meal of the day was early evening.

We spoke with the cook and kitchen assistant who told us most people did not have any special dietary needs. They were aware of people's special needs and preferences and told us they always made an

alternative for people who did not want to have the meals on the menu. A daily sheet showed people's choices. The cook said they spent time talking with people about what they would like and adapting the menu. The menu had a four weekly rotation. We saw plenty of fresh produce, fruit and vegetables, in the kitchen store and the cook had made soup which smelled very good. People told us they enjoyed their meals and had plenty to eat and drink.

People could have breakfast at a time that suited them. Care staff told us nobody required support with eating but some people needed help cutting up food and some required encouragement with their meals. The care notes we looked at contained malnutrition risk assessments that were updated monthly. Three people had food and drink intake charts but these were not always well completed by the care staff, for example nothing had been recorded on the forms for 48 hours from lunchtime on the 21 April to lunchtime on 23 April.

There was a programme of on-line training for all staff to ensure that they knew how to work safely. Topics covered included first aid, fire safety, food hygiene, health and safety, medication awareness, and safeguarding. Senior members of staff were attending training to qualify as moving and handling instructors so they could provide practical training for the staff team. Staff also had practical first aid and fire training. The manager told us all of the care staff were required to complete the Care Certificate. This included staff who already had a national vocational qualification, for whom it would be a refresher/update.

There was a monthly rota for staff supervisions which had previously taken place three or four times a year. The manager told us that supervisions were now going to be done two monthly, with all of the senior staff involved in supervising a group of staff. Staff also had an annual performance appraisal. This meant that staff received regular feedback from their supervisor.

All parts of the home were warm, comfortably furnished, and accessible. There were a number of lounges which meant that people could choose where they spent their time. Some people chose to stay in their bedrooms. There was an adequate number of bathrooms and shower rooms on each floor. Outside there were well maintained grassed areas and a paved patio area, which is the smoking area for people living at the home.

Good

Is the service caring?

Our findings

People who lived at the home told us that the staff provided them with good care and support. One person commented "I love it here." Another person said "It's marvellous." People were well-groomed and appropriately dressed to their own taste. A hairdresser visited two days a week and this was very important to some of the people we spoke with. We also noticed that some people liked to wear jewellery and they told us that it helped their self-esteem to feel that they looked nice.

Everyone had their own bedroom and personal care was provided in a discreet way in the privacy of the person's room. We also saw that staff knocked on people's bedroom doors and waited for a response before they entered. A relative told us "The carers are excellent and the home is spotless. They are all very kind to him." People's bedrooms were personalised with their own belongings such as family photographs, ornaments and small items of furniture which gave them a homely feel.

There was a sense of community within the home and one person who had lived there for a number of years told us "The staff are like my second family. They are all good to me from the cleaners to the higher ups." We spoke with people who were sharing a table in the dining room and they told us "We enjoy a chat and a laugh, some people go back to their rooms after their meals and others go to the lounge." A member of staff said "They are mostly local people and they often find there are people here who they know from years ago." The home was also part of the small local community with facilities close by including shops and a pub that people used.

People were encouraged to be independent and pursue their interests. Most of the people living at the home were able to walk and had a range of mobility aids to help them stay independent. We observed that people kept themselves occupied, for example with newspapers, magazines, puzzle books and television. Some people were able to go out on their own and others went out regularly with their families. One person told us "My daughter's taking me out for dinner."

Care records included information about people's life histories including their occupation, hobbies, and family members. This information helped staff to get to know people and instigate conversations about subjects of interest to them. We observed that staff protected people's dignity and individuality by respecting their choices and preferences. Visitors were welcomed at the service and offered a drink. There were a number of quiet lounges where people and their visitors could go to and have a private conversation.

The service had adopted the 'Herbert Protocol' which is a form with important information about a vulnerable person that is readily available to be given to the police should the person go missing.

A representative from a local church told us he visited the home every two weeks. He told us that the home had a good reputation locally and people were treated well. Some people participated in a small religious service whilst others just liked to have communion or a blessing

People's personal information was kept securely in offices that were locked when unoccupied and this

protected their confidentiality. We also noted the use of room numbers rather than names on files to protect confidentiality.

A copy of the home's brochure and service user guide were available in the entrance area. These provided information about what services the home was able to offer. We also saw information on a noticeboard about local advocacy services that were available for people who did not have close family to support them. However, this was in very small print and not easily accessible. We brought this to the attention of the manager who said she would improve this.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with said they had choices in daily living, for example they could get up and go to bed when they wanted to. One person said "I'm up at 6:30, I've always been an early bird." Another person said "I get up when I want to." People were also supported to choose where they wanted to spend their time and who with.

We looked at the care files for three people. These showed that people's care and support needs were assessed covering all aspects of their health and personal care needs. The assessments fed into a lengthy document called 'My Health Needs'. All of the components of 'My Health Needs' were reviewed monthly, but a significant number of the reviews consisted of "no recent changes" and "no changes recently", with no comments about how the person had been feeling that month.

The care files we looked at showed that people's health needs were monitored, for example they were weighed monthly. There was also evidence that people had access to health professionals as needed, for example GPs, district nurses, optician, podiatrist. We saw that people had the equipment they needed to help keep them safe, for example alert mats for people at risk of falling and pressure relieving cushions.

The care files contained some information about people's wishes regarding end of life care. Members of staff told us they were sometimes able to provide end of life care for people already living at the home with support from district nurses and GPs.

.

There was no planned programme of regular social activities. The manager told us that the home had been without an activities organiser for the last few weeks but two part-time activities organisers had now been appointed. Some people who lived at the home told us they didn't think there was much to do. One person said "There used to be more entertainment and trips out, it's not as good as it used to be." We saw that there were some social events taking place and others planned. People told us they really enjoyed a weekly game of Bingo, and a party was planned for the forthcoming royal wedding.

People we spoke with said they would tell the manager or another member of staff if they had any complaints. The complaints procedure that was displayed on the first day of the inspection referred to the previous provider. The manager took immediate action and updated the complaints procedure so that people had information about who they could contact with any complaints. The complaints procedure gave contact details of people within the organisation and for external bodies that people could get in touch with. The manager said that she had not found any information about complaints that had been dealt with by the previous manager, and she had not received any complaints since taking up post in January 2018.

Good

Is the service well-led?

Our findings

The registered manager had left the service in November 2017 and a new manager took up post in January 2018. The new manager had started the application process for registration with CQC. The new manager told us she had previously been deputy manager at a nearby home and the manager of that home was her mentor in her new role. She was also supported by an area manager and a compliance manager. The compliance manager had visited weekly to start with but was now visiting monthly.

The service also had a deputy manager who had worked at the home for many years and knew the people who lived there very well. She worked one day a week supernumerary to the staff rota to complete supervisory tasks. The home also had a home services manager who supervised the ancillary staff and was responsible for administration duties.

We asked staff and people living at the home about the new manager. One person told us "She's very nice, doing her best." A senior member of staff said "She's not afraid to address issues, I think she'll be fine." and another senior member of staff commented "She has brought the home back up. I was not enjoying coming to work but now I do. I have confidence in her. If you ask her anything she responds."

Following the recent fire emergency, a service commissioner had written "I would like to thank the professionalism of [manager's name] at Whetstone, she maintained a calm and coordinated approach and worked well with fire services, power, and ourselves. They followed the contingency plans and worked very well under considerable pressure."

We saw evidence of regular staff meetings which were well attended. The minutes of the staff meetings showed that staff felt able to express their views. People living at the home told us they attended resident meetings and records showed that these were held regularly. There had not been any relatives' meetings but the new manager said that these would be considered in the future to give relatives a forum to express their views.

There had been no satisfaction survey since the change of provider but the manager told us that forms would be sent out later this year to find out people's views of the home. A suggestions box and feedback forms were available in the entrance area.

There was a schedule of quality audits for the year and these had all been completed to date. We looked at the records and found evidence of regular checks of care plans, kitchen hygiene, meals, laundry, medication, infection control, health and safety, maintenance and gardens, and finance. These were accompanied by action plans for improvement as needed.

The registered provider is required by law to display their current CQC rating in a prominent place within the service. During the inspection we observed that a summary of the home's last CQC inspection report, which referred to the previous provider, was displayed.

The registered provider is required by law to notify the CQC of specific events that occur within the service. Prior to the inspection we looked at notifications that had been submitted by the manager and found that this was being done.