Richard Whitehouse

Wheathills House

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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 7 and 13 September 2016; the first day was unannounced.

Wheathills House is a care home which provides accommodation and personal care for up to 30 older people in rural Derbyshire. At the time of our inspection there were 23 people using the service which provides accommodation with personal care and assistance.

The service had a registered manager who was also the provider of the service. 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 service was last inspected on 14 May 2015, when we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to assess, monitor and evaluate the quality of services and mitigate risks relating to health and safety. In addition, the provider did not ensure staff received the appropriate support, training and supervision. We asked the provider to send us an action plan to demonstrate how they would make improvements to meet the regulations. The provider did not send us their action plan. At this inspection, we found some improvements had been made. However, we identified several areas where improvements needed to be made to the quality of care on this inspection.

Staff recruitment procedures were now robust and the provider had carried out the correct checks to ensure staff were of the right character to work with vulnerable people.

People were involved in the decisions about their care however, staff had not received any training, supervision and support, and they were unaware of their roles in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We saw no evidence of how staff supported people to make decisions relating to their care.

The provider did not understand the need to inform the Care Quality Commission of any accidents, incidents or events at the service, as they are required to do.
Care plans provided information on how to assist and support staff to meet people's needs. Care plans were in a pre-printed format; they were reviewed by the senior care staff, thorough analysis did not take place. People and relatives told us they had not been included in completing or reviewing care plans.

People were not consistently kept safe from the risk of avoidable harm. Risk assessments did not identify what actions or control measures staff should take to minimise the likelihood of harm.

Medicines management and procedures meant people received their medicines as prescribed. People felt

happy and safe living at the service; there were sufficient numbers of staff employed and they were deployed effectively on a day-to-day basis.

Staff knew how to protect people from the risk of abuse and had a good understanding of people's individual needs and preferences.

People using the service were very complimentary about the service and care they received. Staff were caring, kind and compassionate towards people. Staff ensured people were supported in a manner which promoted and respected their privacy, dignity and self-esteem.

People were supported to have food and drinks to meet their dietary needs and personal choices. People were supported by staff to have access health care professionals when it was required. Relationships with friends and relatives were encouraged.

The provider had implemented a system of checking the environment by carrying out audits to assess and review the quality of service.

We found one of breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of Care Quality Commission (registration) Regulations 2009 (part 4). You can see what action we took at the end of this report.

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 not always safe.

The provider had new policies and procedure in place and ensured staff had been checked to ensure they were suitable to work with vulnerable people. People were not consistently kept safe from the risk of avoidable harm. Risk assessments did not identify what actions or control measures staff should take to minimise the likelihood of harm. People felt happy and safe living at the service. Medicines were safely stored and administered.

Is the service effective?

Requires Improvement

The service was not always effective.

Some improvements had been made to staff training, however the provider did not have an effective system in place to ensure all staff were trained to meet the needs of the people. Staff had not received training with regards to their responsibilities under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). People were supported to access health care as necessary; food and drinks catered for people's individual choice, preference and specialist guidance.

Is the service caring?

Good

The service was caring.

People and relatives praised the quality of care. Staff took time to get to know people to enable them to provide care which was focused on individuals. Staff treated people with dignity and respect, and encouraged them to remain independent. Relatives were encouraged to remain actively involved in their family member's life; they could visit whenever they wanted.

Is the service responsive?

Good

The service was responsive.

Care plans were reviewed by supervisors, although thorough analysis of the information did not take place; people told us they had not been included in completing them. People were not asked for their views about the service; although they knew how and who to complain to should they not be happy with their care. There was an activities coordinator who provided a range of activities. People were supported to continue to enjoy hobbies and interests and to follow individual religions and beliefs of their choice.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider did not seek the views of people or relatives to improve the service. Accidents and incidents were recorded, however the provider did not conduct any analysis to learn from or reduce risks of re-occurrence. We saw no evidence to suggest staff received supervision or support. Environmental audits for health and safety had been implemented. People, relatives and staff spoke positively about the staff.

Wheathills House

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.

Before the inspection we reviewed the information we held about the service along with notifications that we had received from the provider. A notification is information about important events which the service is required to send us by law. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to our inspection we contacted the local authority contract and commissioning team and took the information they provided into account as part of our planning for the inspection.

This inspection took place on 7 and 13 September 2016; the first day of this inspection was unannounced. The inspection team comprised of one inspector and an expert by experience, who had specific experience of older people and dementia care services.

We spoke with twelve people who used the service and six members of staff. We also spoke with the provider, a pharmacist and two health professionals who visited people at the service. We reviewed a range of records about people's care and how the service was managed. This included three people's care plans, all staff records, health and safety audits and medicines records.

Not all of the people living at the service were able to fully express their views about their care. We used the Short Observational Framework for Inspection (SOFI) to capture the experiences of people who may not be able to communicate their views.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in May 2015 we found an on-going breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to take action to improve their recruitment processes and ensure people employed were suitable to support people living at the service.

We took enforcement action against the provider, and at this inspection found improvements had been made. The provider had completed disclosure and barring service (DBS) checks for all staff. The DBS helps employers ensure staff they recruit are suitable to work with vulnerable people who use care and support services. Confirmation of all staff member's identity had been sought and checked; information was also held regarding who to contact in an emergency. The provider had purchased new policy and procedures, which all the staff had access to as a point of reference and guidance. This meant the provider had checks in place to help ensure that people were supported by staff who were suitable to provide care.

People said they were happy living at Wheathills House and generally felt safe. One person said, "I feel very safe here; it is very nice and as care homes are I don't think it could be bettered." Another person said, "I feel very safe; I've never had any problems." A third person said, "I feel very safe, especially in night which was a problem for me at home and why I decided to try it."

Staff were able to identify concerns and understood they were responsible for people's safety. Staff we spoke with an understood different types of abuse and were aware of how and who to report any safeguarding concerns to. Staff knew about the Whistleblowing policy and they knew how to escalate their concerns if necessary.

People and relatives told us there were enough staff available to meet their needs, although one relative told us they thought there were not always enough staff. We reviewed the duty rota and saw staff levels were maintained at the level set by the provider. There was call bell system in place, and the provider was able to monitor response times from the main board in the office. When bells sounded, we saw staff responded in a timely manner.

People were not consistently kept safe from the risk of avoidable harm. Risk assessments were contained within care plans and were reviewed monthly by the care supervisor. However, these did not identify what actions or control measures staff should take to minimise the likelihood of harm. Where changes had been recognised, there were no updated guidance for staff to follow, to support people's changed needs. For example, we saw a changed had been recorded to one person's 'moving and handling assessment', however there was no updated care plan to support this change. Risk assessments were not consistently reviewed or analysed following accidents or incidents. For example, we saw no evidence of people being referred for falls assessments following falls at the service. We spoke with the provider about this, and they acknowledged analysis was needed to ensure risks to people were reduced.

People told us they received medicines when and how they should. One person told us, "Staff bring me my tablets on time." They went on to say, "They always get them right." We saw medicines were provided in a

pre-prepared 'pod' type system and were administered by senior staff. Medicines were ordered and stored in a safe manner. We observed senior staff administer medicines and saw people were not hurried or rushed. Staff offered people a brief explanation as to what the medicine was and what it was for.

We saw staff who administered medicines carried trays of medicines around the service when they were carrying out the medicines round. We discussed this with the provider and the staff, as we were concerned for the safety of this process. On the second day of our inspection, we were told by the provider, they had ordered a new medicines trolley, to enable staff to safely transport medicines. We spoke with a pharmacist, who was complimentary about the staff and medicines procedures in place at the service. The provider had an up to date policy which was accessible for staff who dealt with medicines. This helped to support medicines being managed in a safe manner.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found the provider could not assure us staff had the relevant knowledge or skills to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider for an action plan, however did not receive one.

We saw there had been some improvement in relation to staff training. We saw certificates were held at the service to confirm staff had attended a collection of training courses, which included, infection control, safeguarding, dementia awareness and emergency first aid. However, one staff member we spoke with told us they had not yet attended updated training. The provider told us training was, "A work in progress." Following our inspection, the provider sent us their proposed training matrix. This meant people could not be assured all the staff had up-to-date knowledge and skills to meet their needs.

At our last inspection in May 2015, we recommended the provider ensured staff received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). At this inspection we found staff had yet to attend any training in relation to MCA and DoLS.

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). At the time of the inspection the provider told us all the people living at the service had made their own decision about staying there. During our conversations with people, we were able to confirm people had made the decision to stay at the service. One person told us, "I had a trial visit; I came for respite when [my relative] was poorly and then decided to move in later when I realised I needed more care than he could provide."

We checked whether the service was working within the principles of the MCA. Staff we spoke with were unclear of their role and responsibilities with regard to it. They told us the provider had not arranged any training in the MCA and how to support and care for people who were not able to make and understand decisions in relation to their care. The provider told us, when people's needs increased, relatives would be told so they could look for alternative arrangements for their family member.

We saw people's care plans and it was unclear how decisions had been made; we saw no evidence or records of any best interest meetings taking place. Staff did not understand the key principles of the MCA and DoLS or how to support people to make their own decisions.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were happy with the care and support provided by staff at the service. One person told us, "I came here for a short stay and decided to stay." Another person said, "I am glad I came for respite as it helped me make up my mind about future. I enjoyed it so much; I missed it when I went home and decided much better life in here." A third person said, "I used to visit friends here and then came for respite a couple of times about three years ago. I think best thing is to try places first with respite." People told us they were happy with the care the staff provided and felt their needs were met. We saw staff provided people with support in a manner which was in accordance with their wishes and preferences.

People were complimentary about the food and the standard of meals at Wheathills House and told us they enjoyed the meals and drinks provided. One person said, "The food here is very good. Excellent." Another person said, "Food-yes I look forward to it. I have all my meals here in my room; I told them this is what I want." They continued and said, "There's always plenty to eat and I think there is enough variety and choice on the whole." A third person said, "There is always a choice of two dishes for lunch and tea; for desserts as well and always plenty, ample. Can also ask for more if you want."

At mealtimes, the dining areas looked attractive and welcoming, having been laid with tablecloths, napkins, cutlery and drinks of people's choice. At lunchtime there was a choice of drinks including wine as well as juice and water. We saw staff were polite and respectful, and people were asked about choices and preferences. The food provided was homemade and people were positive about the quality and quantity provided. People confirmed there was always a choice at each meal, which reflected their individual preferences.

We spoke with the cook who was able to tell us about any specific dietary requests people had. The cook was aware of and catered for, people who required special diets. For example, suitable choices and meals were provided for people with diabetes. Food was also prepared
in the correct consistency and calorific value for people who required soft or fortified diets because of their health needs. The cook told us they had met with the speech and language therapist (SALT) to ensure the food and drinks they provided for one person was the correct consistency. This was confirmed by the SALT, who told us, when recommendations and guidelines for specific food and drinks had been provided, the staff ensured they were followed.

People's physical health was supported and the service had regular visits from health care professionals. One person said, "If you are feeling unwell and you tell them, they talk to you about it and get the GP out without any hesitation." Another person said, "The chiropodist comes in and I see him but I still go to the opticians in Derby; [relative] sorts it and takes me." A relative said, "They (staff) may sort it out for others if there's no family, but I take [relative] to all his appointments and keep track of them." Staff were aware of the need to monitor people's health needs and refer to the appropriate professionals as and when required. A health professional told us the staff kept them informed of any changes to people's needs and health. They described communication systems as, "Effective." They told us staff followed any guidance to ensure people's health and welfare needs were responded to. We saw the daily diary contained information which supported people receiving visit's and treatments from health professionals. This meant people's health needs were effectively supported and met by the staff.

Good

Is the service caring?

Our findings

Most people we spoke with were very positive about the way staff treated them and the level of care they received at Wheathills House. Words used often by those we spoke with included, "Caring, understanding, friendly, warm, helpful, attentive and hard working." One person told us, "I'm only here for respite for a week but the care, attention and kindness is wonderful." Another person told us, "They are very kind; they look after you and will do anything for you. " A third person told us, "There is not one member of staff I could say anything bad about."

People felt staff provided choices in their daily routines and activities of daily living and we observed this to be the case. We saw staff explained to people what they wanted or were about to do and asked each person if that would be alright.

Throughout the day, we saw staff being helpful, compassionate and caring. We saw and heard staff speak with and respond to people in a calm, considerate and respectful manner. They spoke politely with people and called them by their preferred names. Conversations with people were not just task related and we saw staff regularly check out understanding with people rather than just assuming consent. We saw staff knocked on people's doors and waited before entering. We saw people were dressed in clothing that was clean and appropriate for the time of year; they were dressed in a manner which maintained dignity and promoted their esteem.

People felt staff treated them fairly, showed respect for their privacy and dignity and people's right to a private and family life was respected by staff. We saw staff discussed people's care needs in a discreet manner. For example, we saw a staff member subtly ask people if they needed to visit the toilet prior to lunch. Staff ensured information about people's health and social care needs was securely stored. Staff understood the importance of maintaining and respecting people's confidentiality, however they also understood when it was appropriate and necessary to share essential information.

People told us they were encouraged to be as independent as they could. We noted, people were encouraged to walk the short distance from their bedroom or lounge, to the dining room. When someone was tiring, we saw the staff offered to get them a chair. People were also encouraged to manage their personal care, if not totally, then in part. We saw there was a small kitchen and seating area where people could make themselves a hot drink, although we did not see anyone attempting this, rather they asked the staff or visitors to help. We saw most people were able to eat and drink independently, but there was one person who seemed a little confused as to how to hold and use their cutlery when lunch was placed in front of them. The staff noted this immediately and offered assistance to remedy this and thus enabled the person to eat their meal independently.

Good

Is the service responsive?

Our findings

We saw the staff knew people's likes, dislikes and preferences in relation to their care. One person said, "They know what I like, for example what time I want to get up and go to bed, how I like to spend my time, where I like to sit, how I like my coffee, what help I like and what I like to do for myself." They continued and said, "They always ask before doing things but know for example that I prefer to shower myself in the morning."

We saw people had an individual care plan, which contained personal information about them. Each care plan was reviewed regularly by the supervisor. Care plans included people's preferences, likes and dislikes, along with what was important to them. However, one relative said, "[Relative] does not have a care plan. I was told [relative] did not need one for respite but since [relative] has come back and is staying permanently, then home have said would need to do a care plan. I have asked to be involved in this as well as [relative]." We checked and saw this person's care plan had started to be completed by a supervisor.

We saw the service used two desktop diaries for daily notes about people. One diary was for daytime and one for night-time. We spoke with the provider about this as we were concerned some crucial information may be missed. The provider told us they were considering looking at alternative ways of recording people's day-to-day information, to help with continuity and consistency.

We saw no evidence of people being asked for their views on their care. None of the people we spoke with could tell us when they last took part in a review of their care plan. People told us they were aware of who they should and could speak with if they were unhappy, or had concerns or complaints. Most people said they would either speak with the provider or supervisor, although several people told us they would tell a family member. One person told us, "I would speak to one of the overseers (supervisors) first if I was not happy." They went on to tell us, "There's always one on duty in the day and they are very friendly, but I have never had to do this and I certainly have no complaints." People told us they were confident the provider and staff would take any concerns seriously. We saw a complaints procedure was in place, although there was no evidence of any formal complaints having been made.

Staff spoke in a positive manner about the people they supported and cared for; they had taken time to get to know people's preferences and wishes. Staff had a good knowledge of people's care needs and this was demonstrated in their responses to people and recognition of when people required additional assistance. For example, at lunchtime, we saw one person had difficulty with coordination and staff ensured a non- slip tablemat was in place to assist them. Two people told us, they were hoping to be able to move downstairs when rooms become available. They told us this was to enable them to be more independent about the service. People and their relatives generally praised the staff and told us they had no concerns regarding the care and support being provided.

People were provided with regular activities, which were led by the activity coordinator. During our inspection we saw the activities consisted of a topical themed quiz and chair based exercises. Throughout the activity session, people were included and brought into the conversation by the coordinator. People told

us how much they enjoyed the activities provided, although some people told us they would like more. We saw there were times when external entertainers visited the service and people told us they enjoyed this. The coordinator also arranged for a Christian church service to take place once a month. Some people were also visited by members of their own faith, and this enabled them to continue to practice their personal religious belief.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in May 2015, the provider was unable to demonstrate to us how they audited their service and ensured it was safe. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider for an action plan but did not receive one.

During this inspection we looked at whether or not improvements had been made. We found some improvements had been made, however further improvements were still required.

At this inspection, we found the provider had implemented a system of auditing the health and safety and environment. We saw the provider or domestic staff carried out audits in such areas as, general cleanliness, fire alarms, lighting and water temperatures. We saw any problems identified by the audits were remedied by the provider.

The provider did not notify the Care Quality Commission (CQC) of significant events, as we would have expected. For example, we saw there had been occasions when people had sustained accidents and injuries which required hospital treatment or admissions. The provider also failed to notify us when events which affected or stopped the running of the service occurred. For example, we were not informed of a power cut and how the provider remedied this to ensure people were kept safe. We raised this with the provider and they acknowledged they were unsure as to what they needed to report and notify us of.

This meant, the provider had breached Regulation 18 of the Care Quality Commission (registration) Regulations 2009 (part 4).

Accidents and incidents were recorded, although we found the provider did not carry out any analysis or monitoring for any actions or control measures. For example, we saw people were not referred to a falls clinic for specialist support where this was needed. We saw there were no consistent systems in place to mitigate or reduce risks in relation to people's health, safety and welfare. Following this inspection, the provider sent us an updated falls management policy and procedure.

We recommend the provider finds out more about local falls teams and services available, to assist in analysis, assessment and procedures relating to falls and unforeseen accidents.

We did not see evidence of any formal survey or questionnaire being in place, although the provider told us they people and relatives gave feedback in an ad-hoc manner. One person told us, "We did have a kind of residents list to put on what we wanted. Was general and about all aspects of living here but was over a year ago and no-one bothered to fill it in." We saw the provider and staff were friendly and familiar with relatives and visitors. Throughout the inspection, we saw people and relatives visited the office and sought out the provider to clarify queries, arrange appointments or just to say hello. People told us they felt confident in raising any concerns or worries. One person said the service was, "Run well with good Staff. Good management, as far as I can see they treat everyone same; I've no complaints."

During our inspection a relative gave a thank-you card and gift of chocolates to share to thank staff for the care their family member had received. We saw records of 'residents' meetings conducted by the activities coordinator. The records showed people were given the opportunity to raise any concerns and suggest improvements. This was then fed back to the provider for them to action or respond to. For example, people had made requests for certain meals to be added to the menu; we saw the requests had been carry out.

Generally, staff felt there was good team-working; they felt supported by each other. Staff were however, unable to tell us when they last received any supervision from the supervisor or provider. Supervision is a process by which staff are provided with support and guidance from their line manager. This meant, staff were not given the support and guidance to ensure their practice was current, safe and effective.

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 18 Registration Regulations 2009 Notifications of other incidents The provider did not notify the Care Quality Commission (CQC) of significant events, as we would have expected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff did not understand the key principles of the MCA and DoLS or how to support people to make their own decisions.