

Summerfield Medical Limited

Whittington House Nursing Home

Inspection report

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

About the service

Whittington House is a residential care home providing personal and nursing care to up to 66 people. The service provides support to older people predominantly, some of whom live with dementia. At the time of our inspection there were 38 people using the service.

Whittington House is a purpose built care home and people are accommodated in one building. There are four named units, although at the time of our inspection, people were only living in three of the four units. One of those units specialises in providing care to people living with dementia.

People's experience of using this service and what we found

People told us they felt safe and there were processes in place to safeguard people from abuse. People confirmed they received their medicines and support to take these as prescribed. Monitoring arrangements were in place to reduce the risk of medicine errors. Risks to people's health were assessed and action taken to reduce or mitigate risks. Environmental risks were assessed and managed, so these were reduced or mitigated. Arrangements were in place to maintain the safety and upkeep of the building as well as the outside spaces. Maintenance and servicing arrangements ensured the service's equipment, utilities and emergency systems remained in working order.

The provider had experienced significant challenges in retaining and recruiting staff, but some progress had been made with the recruitment of new staff. The provider used agency staff to support safe staffing numbers and to support the running of the service overall.

At the time of the inspection the manager and deputy manager were providing leadership and support to the staff. The provider had arrangements in place to support this management team. Just prior to the inspection, the manager had resigned so the provider had organised for further management support arrangements to be in place once the manager had left.

There were systems and processes in place to assess and monitor the quality of the services provided to people, including to assess and monitor the service's compliance with necessary regulations. The provider had sought and acted upon feedback from people, their representatives and staff to improve the service. Improvements had been made to monitoring clinical and environmental risks, records systems and care plans, the management of concerns and complaints, people's food choices and support for nursing.

Progress against ongoing areas for improvement was monitored through the provider's quality monitoring process. For example, this included the current continued monitoring of the cleaning and support for the housekeeping team whilst waiting for the recruitment of additional housekeepers. Staff who wished to be dementia ambassadors had been identified and were due to start their training as part of the provider's new dementia strategy.

People and relatives told us they had appreciated the improved communication and engagement arrangements which the manager had put into practice. They described the manager as being visible and approachable; willing to listen to their concerns and take action to try and resolve them. Lessons had been learnt from the feedback provided from relatives about the previous lack of response in relation to their concerns and complaints.

Nurses and senior care staff were being empowered and supported to develop their leadership and supervisory skills. Processes were in place to improve communication between departments and to ensure all departments worked together to support people who used the service.

Managers and staff worked with various health and social care professionals to support people's access to the service when needed and to ensure their health and social care needs were met.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was good (published 15 November 2019).

Why we inspected

We received concerns in relation to staffing numbers, staffs communication skills, the management of people who live with dementia and who have behaviours that can cause distress or potential harm to others, the management of medicines and complaints and the cleanliness of the care home. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection these were rated to calculate the overall rating.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Whittington House on our website at www.cqc.org.uk.

Follow up

We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Details are in our safe findings below.

Is the service well-led?

Good ●

The service was well-led.

Details are in our well-led findings below.

Whittington House Nursing Home

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

One inspector and an Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Whittington House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Whittington House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. The previous registered manager had left in May 2022. The manager had completed an application to register with CQC but, confirmed during this inspection, they were leaving Whittington House so their application will not be forwarded to us.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used all this information to plan our inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection

We spoke with nine people who used the service and 13 relatives to gain their view of the services and care provided. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with two care staff, the activities co-ordinator, housekeeper, chef, maintenance person, deputy manager, interim manager, regional manager, quality manager and a health care professional.

We reviewed a selection of care plans and risk assessments relating to the care of seven people. We reviewed records relating to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) including records relating to the administration of covert (hidden in food or drink) medicines. We reviewed two staff recruitment files and the service's training record. We reviewed a selection of records and documents relating to the management of the service. These included a selection of in-house and provider audits, the home improvement plan, meeting minutes, feedback surveys, selection of policies and procedures and information on the provider's dementia strategy called 'My World'.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. The rating for this key question has remained good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- There were processes in place to safeguard people from abuse. Staff had received training on how to recognise abuse which included how to report their concerns. Managers followed the local authority's safeguarding protocols, which included reporting safeguarding concerns and incidents and sharing relevant information with external agencies when requested. This included with the police and CQC.

Assessing risk, safety monitoring and management

- Risk monitoring and management processes were in place. Risks to people were assessed and action taken to reduce these. This included, risk of falls, pressure ulcer development, malnutrition and choking.
- Environmental risks were assessed, and action taken to reduce and mitigate these. These included potential risks that can be associated with fire, utilities and equipment. Maintenance and servicing arrangements were in place to help mitigate risks.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Staffing and recruitment

- The provider's recruitment process was followed so risks to people from staff who may be unsuitable were reduced. Checks through the Disclosure and Barring Service (DBS) had been completed before staff worked with people. These checks include details about convictions and cautions held on the Police National Computer. Employment histories were also explored, and any gaps accounted for. References were also sought from previous employers. All of this information helps employers make safer recruitment decisions.
- Due to significant challenges in recruiting permanent staff, agency staff were used to support safe staffing numbers. The provider took measures to assure themselves that the agencies they used also appropriately

recruited their staff.

- Staffing numbers for care were determined using a dependency assessment tool. When organising staffing rosters, managers considered staffs skills and experience to ensure the right mix of staff. The deployment of staff was reviewed regularly, and staff redeployed when needed. For example, to support different areas of the care home during busier times of the day such as meals times and to support the housekeeping staff.
- People and their representatives gave mixed feedback about the staffing arrangements. Comments included, "I feel safe. They rely on agency workers, but staff get used to you, if they are permanent", "There are plenty of staff and I get on with them. The night staff are good, they keep an eye on me, I can't fault them", "There is not enough staff, but they know her and look after her well" and "They are starting to recruit more permanent staff."
- An ongoing recruitment campaign was in place and nurses and a second chef had recently been employed.

Using medicines safely

- People's medicines were administered by staff who had received training to do this and whose competencies in this task were checked.
- There were processes in place to support safe medicines management. This included regular checks to help mitigate medicine errors and reduce the risks to people associated with these.
- People's medicines were reviewed by a GP or supporting pharmacist to ensure people's prescribed medicines remained relevant and appropriate to their needs. A person told us "We receive good care and our prescriptions have been simplified, we get them (the medicines) on time, and have regular visits from a doctor."
- Community nurses provided support when required to ensure people received their medicines as prescribed, for example, at the end of people's lives to ensure them remained comfortable.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. At the time of the inspection cleaning of the care home was taking place but more cleaning staff were required to fully support the home's needs in this area.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- There were no visiting restrictions in place at the time of the inspection. People were able to receive visitors as they wished.

Learning lessons when things go wrong

- Learning had been taken from challenges recently experienced when supporting people who lived with dementia. The needs of people, prior to future admissions, would be considered along with staffs' skills and staffing numbers at the time and, in some cases, whether access to specialist support was in place if needed.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. The rating for this key question has remained good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The manager and deputy manager worked well together and were promoting an inclusive and positive culture. People and their representatives felt able to approach either manager with any concerns they may have and told us communication had improved. Comments included, "If anything was wrong, I would go to (manager). I have complained, and they responded satisfactorily and in a timely way" and "The manager is brilliant, perfect for the job." A member of staff said, "I get on well with (manager) and (deputy manager)."
- Staff were being supported and empowered to work effectively together. There had been a focus on team working, across all departments. The initiative 'resident of the day' had been implemented. The manager told us it was sometimes a challenge to consistently complete this with the current staffing arrangements, but it provided a framework for achieving a more person-centred approach to people's care and support.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The manager and deputy manager fully understood their responsibilities in relation to duty of candour.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At the time of the inspection the manager informed us they had resigned just prior to the inspection. They had intended to register with CQC and had completed their application form but would now not be submitting this to us. The regional manager informed us of the management plans for the service when the manager left and they were aware of the service's requirement to have a registered manager.
- The manager and deputy manager were clear about their different roles and responsibilities and they were supporting their senior staff to be clear about their roles and responsibilities and to work in accordance with their job descriptions.
- Quality monitoring processes were in place to assess and monitor the safety and quality of the services provided to people. Audits were completed by both managers and action taken to address shortfalls. Both managers were fully aware of where improvements were required, and action was being taken to address these areas. For example, managers were waiting for a specialist company to connect the home's cordless call bells to the home's call bell system, so some people could be provided with this option rather than their current fixed call bell. Although carpets had been cleaned by an external company they required further cleaning which was being organised and the next steps of the provider's new dementia strategy were to be implemented.

- Several improvements had been successfully achieved which included, increased support and supervision for nurses, implementation of regular clinical risk meetings, improved medicines management, improved care records following the implementation of an electronic care records system, improved quality and choices of food and better management of complaints and concerns.
- The service's improvement plan recorded the progress made against all actions for improvement. The service's provider representative monitored progress against these and checked and signed off completed actions. They provided the provider with a regular report on the service's progress and performance. This enabled the provider to direct support and monitoring resources as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The manager had improved communications and engagement with people and their representatives, and we received positive feedback about this. Comments included, "The manager has spoken to me, and asked if I want any changes, things like that, he's interested to make everything agreeable to all patients" and "(Manager) is much more communicative. He has arranged some evening meetings."
- Planned meetings were taking place with people, people's representatives and staff to impart information but also to seek feedback as part of a quality assurance process.

Continuous learning and improving care

- Learning had been taken from the feedback provided by some people's representatives about the lack of management of their concerns and complaints. Improvements had been to the visibility and approachability of managers, to how concerns were received, listened to and responded to. The management of a concern or complaint was to be more fully monitored during the regional manager's visits to ensure these remain managed in accordance with the provider's complaints policy and procedures.
- Following review and transfer of people's care plans onto the new electronic care records system, people and their representatives were due to be provided with opportunities to review these and to provide feedback, which would go towards improving people's care.

Working in partnership with others

- During the pandemic staff had worked with paramedics, NHS Response teams and GPs to treat people who had contracted COVID.
- Managers and senior staff worked hard to ensure people had access to specialist health care professionals when needed. This included mental health practitioners and continuing health care practitioners when an assessment of health needs was required.
- Managers liaised with adult social care and health commissioners to support admission to the care home when it was needed.