St. Martin's Care Limited

Washington Manor Care 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?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service: Washington Manor Care Home provides accommodation and personal care for up to 68 people, including people living with a dementia. At the time of the inspection 64 people were using the service.

People's experience of using this service: Medicines were not managed safely. Risks were not always identified. Information from accidents and incidents was not carried through into people's care records to support staff to reduce the risk.

The service did not effectively support people with the risks associated with malnutrition and hydration. Some people were not receiving supplements to their diets as directed by a healthcare professional. Recording was poor and we could not establish if people had received adequate fluids.

Pre-assessments were not always completed and did not cover all the protected characteristics of the Equality Act. Care records were not always accurate or up to date. The service failed to adhere to the Mental Capacity Act 2005 (MCA), mental capacity assessments and best interest decisions were not in place.

Some staff did not have all the appropriate training to support people safely.

Management checks were not robust and when audits found issues the service was slow to make things right. People's information was not held securely. Record keeping throughout the service was chaotic. Documentation was not fully completed, contained inaccurate information and in some cases, was missing.

People and relatives told us staff were kind and caring. We observed staff were very busy supporting people and had limited time to sit and chat with people. Staff were keen to do the right thing and determined to provide great care and support for people.

A range of group activities were available for people to enjoy. Although there were limited options for men and for people on bed rest.

The provider set about resolving issues we identified following the first day of inspection, creating an action plan and placing additional staff to support the home.

Rating at last inspection: At the last inspection the service was rated good. (Report published 2 August 2018).

Why we inspected: This inspection was brought forward following concerns raised to us. These included concerns around staffing, provision of care and hygiene, nutrition and hydration. We also shared these concerns with local authority safeguarding and commissioning teams.

Enforcement: We identified 5 breaches of the Health and Social Care Act (Regulated Activities) Regulations

2014 including safe care and treatment, need for consent, nutrition and hydration, person-centred care and good governance.

Follow up: We will continue to monitor the service and will undertake another comprehensive inspection within six months.

During the inspection the provider submitted an action plan in response to the serious concerns letter we sent to them and has started to address issues identified.

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

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.

Details are in our Safe findings below.

Is the service effective?

Inadequate

The service was not effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Washington Manor Care 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, 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 prompted by information shared with CQC which indicated potential concerns about staffing levels, care provision and nutrition and hydration.

We initially examined those concerns, but due to the risks identified we conducted a comprehensive inspection.

Inspection team: The inspection was completed by two inspectors and a specialist nurse advisor.

Service and service type: Washington Manor Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was a manager in the service but they had not yet registered with CQC. They had started their application to become registered. It is important for a manager to be registered with CQC so they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The inspection was unannounced.

What we did: Before the inspection we used information about the service to plan. We reviewed notifications sent us to us about certain incidents that had occurred that the provider must tell us about. We contacted the local authority commissioning and safeguarding teams to see if they had any concerns about the

service.

Due to the responsive nature of this inspection, the provider did not complete a Provider Information Return (PIR). Providers are required to send us key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

Some people who used the service were unable to tell us about their experiences. 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 looked at the care records of nine people, a sample of medicines records and other records related to the management of the service. We spoke with ten people using the service, two relatives and a visiting healthcare professional. We also spoke with the head of care services, the manager, deputy manager, quality manager, eight care staff, three seniors, the cook and the activities co-ordinator. Following the inspection we spoke with two healthcare professionals.

Requires Improvement

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Using medicines safely.
• Medicines were not managed safely. The service failed to follow NICE Guidance for the management of medicines.
• Medicines administration record sheet (MARs) were not always fully completed.
• Room and fridge temperatures were not regularly recorded. We noted the temperature in one treatment room was above the appropriate temperature for a number of days and no action had been taken to address the matter. High temperatures can affect some medicines.
• Guidance for the use of 'as required' medicines were not always in place.
• Certain medicines required a body map for staff to record the position of a patch on the person's body. This is to support the removal of the last patch and to stop the repeated placement on the same area which can cause side effects. We found these were not always in place.
• Some prescription medicines are controlled under the misuse of drugs legislation. These medicines are called controlled drugs and have stricter legal controls applied to prevent them being misused. One person's controlled drugs were still in the service when it should have been returned to the pharmacy.
• People's allergies were inaccurate or were not recorded within people's care records and on their MARs.
• We asked the manager to address the issues identified which they did immediately.

This failure to manage medicines safely demonstrated a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Assessing risk, safety monitoring and management.
• The management of injuries caused by falls were not dealt with appropriately and placed people at risk. One person had a fall which resulted in a head injury. The service failed to follow their own policy in regard to carrying out observations. Another person had a fall and follow up advice had not been added to the person's care records to mitigate the further risk.
• Risks to people were not always identified. One person was taking a medicine which stated not to drink grapefruit. We found this information was not included in the person's care plans.
• Where people were assessed as needing support to reposition in bed, as part of their pressure relief, records contained gaps or were missing. The manager assured us that repositioning was taking place and advised it was poor recording keeping. However, records provided to us following the inspection still contained errors. For example, one person's record reported they had transferred to and from a chair to a wheelchair whilst daily notes stated the person was in bed during the same period.
• Personal Emergency Evacuation Plans (PEEPs) were out of date and contained inaccurate information about people's current support needs. This meant in an emergency people were at risk of being supported in an unsafe manner.

• Care plans did not provide guidance for staff for the management of behaviours encountered when a person may become agitated or distressed.
• On a number of occasions, we observed call bells out of reach of people which meant they were unable to call staff if they required help.

The failure to identify and respond to risk demonstrated a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

• The provider had contingency plans in place to support people in emergency situations.

Staffing and recruitment.
• The service used a dependency tool to determine staffing levels. The head of care service advised that the service maintained the appropriate staff levels.
• We noted whilst staff were busy supporting people in their rooms people were left unattended. On two occasions we had to find a staff member to support people; one person became upset and agitated. On another occasion a person living with dementia was boiling a kettle full of water. This posed a risk of scalding to the person and others present.
• Staff told us they did not think enough staff were available to meet people's needs. One staff member told us, "We try so hard and we care. I want to do the best but there isn't enough of us."
• Relatives and people we spoke with did not raise concerns about staffing levels. One relative said, "The staff always pop in and check on [family member]."

We recommended the provider reviewed the way it deployed staff.

• The provider followed effective recruitment procedures, including completing pre-employment checks to ensure new staff were suitable to work at the home. The service had identified that references were not always obtained before staff started work and were addressing the matter.

Preventing and controlling infection.
• On the first day of inspection we found clean linen stored next to dirty items placed in a shower room. The provider advised that the matter would be addressed and immediately ordered new laundry systems with lids. However, on our third day of inspection we found poor practices continued to be followed.
• Staff had access to and wore gloves and aprons.
• The home was clean, well decorated and maintained.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong.
• 58% of staff had valid safeguarding training.
• The service had systems in place to investigate any safeguarding concerns and these were referred to the appropriate agencies.
• Accidents, incidents and safeguarding concerns were collated and reviewed for trends or patterns. However, we found accidents were not always recorded
• Recordings of people's daily care and handovers between shifts were not robust meaning messages about changes in people's needs and risks were not always passed on. For example, following a fall, a person had sustained a head injury which required a dressing to be applied. This occurred nine days prior to the inspection. We asked the manager about the injury and they advised they were not aware of the incident.
• A compliance visit report had identified issues and outlined actions, with a timeline for completion. Some had been reported as 'started' to be addressed however, these were at an early stage.
• The provider immediately submitted an action plan to the commission following the identification of concerns on the first day of the inspection. They also addressed the issues we highlighted in the letter of

serious concerns and gave assurances to resolve the issues.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Supporting people to eat and drink enough to maintain a balanced diet.
• The service did not always support people in line with guidance from healthcare professionals. Two people had been prescribed fortified meals to support them due to weight loss. This information had not been passed to kitchen staff and had not been added to people's care records. This resulted in the people not receiving the supplements to support their nutritional needs.
• One healthcare professional was provided with information about a person which was inaccurate and as a result the person's treatment was changed.
• Where people required their food and drink to be monitored we found records had not been fully completed. We reviewed associated records, such as the administration of thickener to support people at risk of aspiration. Thickened fluids and thickened drinks are often used for people with dysphagia, a disorder of swallowing function. These records were also not fully completed. This meant we could not establish if people at the risk of aspiration were supported safely and if people had received adequate fluids.
• People who had been identified as risk of malnutrition had their weight monitored. A central record of people's weights for the current and previous months contained inaccurate and missing information. Some records did not match the information recorded on the person's individual weight record. This meant referrals to healthcare professionals were not always made in a timely manner. The manager assured us this was poor record keeping and had created a new daily record sheet to support staff. These sheets did not always have information about what fluid and food targets people should be working to, or what to do if people did not achieve this. Following the inspection we made referrals to the local safeguarding team for three people.
• We asked the manager to investigate the failures in the systems in regard to people not receiving nutritional supplements as directed by a healthcare professional. Also, to review other people's weight loss. The provider confirmed this had taken place.

The concerns identified in relation to people's nutrition and hydration demonstrate a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

• Feedback about the meals was varied. Some people told us they enjoyed meals, but others said they wished they had better choice.

Ensuring consent to care and treatment in line with law and guidance.
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• Information about people's mental capacity to make decisions was not clear in people's care plans.
• When people lacked capacity to make their own decisions, we found mental capacity assessments and best interests decisions in relation to restrictions placed on people, such as bed rails, were not in place.
• Care plans referred to relatives having lasting power of attorney (LPA) but did not regularly detail the type and copies of the documentation were not available. LPA is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future. Following the first day of inspection the manager wrote out to relatives to obtain copies of the legal documentation.

The services failed to adhere to the principles of the MCA demonstrates a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Some pre-assessments were blank or not completed. The pre-assessments did not ask questions to support all the protected characteristics of the Equality Act. The head of care services advised that a new pre-assessment was in place to address that matter.
• People's care plans did not always outline people's preference in the way they wished to be supported. One person with a visual impairment preferred to be supported by staff in a particular way. Whilst staff supported the person as they wished there was no mention of the method in the person's plan which meant staff who were not familiar with the person would not be able to support them as they preferred.

The lack of assessment of people's needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience.
• Training was not up to date. We noted some training had lapsed in July 2018 and the service had been slow to address this.
• 49% of staff had valid first aid and 56% moving and handling training. The provider had identified that some training had lapsed. However, staff without current moving and handling were allowed to support people. We questioned this practice with the manager who assured us they were confident staff were competent. No competency reviews had been completed.
• On the second day of the inspection we observed an unsafe transfer when staff failed to apply the brakes on a person's wheelchair whilst transferring with a hoist.
• The provider had taken on a new training provider to deliver training for all staff. This was to start in April 2019.
• Newly recruited staff completed induction training.
• The manager had begun supervisions with staff in January 2019. Staff told us they received regular supervisions and appraisals.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support.
• Record keeping was poor and we were unable to determine if follow up appointments with healthcare professionals had taken place. One relative told us that their family member had missed three hospital appointments. They advised that they had taken this matter up with the manager.
• Records of when healthcare professionals had visited or been contacted were not always completed and guidance provided was not always adopted in people's care records.

Adapting service, design, decoration to meet people's needs.
• People had access to large communal areas, a quiet lounge and a garden area. Corridors were wide for easy access for those using a wheelchair.
• Storage was limited. We found bathrooms and shower rooms had been used to store laundry trolleys, wheelchairs and hoisting equipment. People's en suite bathrooms were also used to store wheelchairs and continence pads.
• The service had created a double room to accommodate a married couple. People's rooms were personalised to their choice.
• Some visual signage was available to support people living with a dementia to orient themselves around the service.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity; respecting and promoting people's privacy, dignity and independence.
• Information regarding the protected characteristics of the Equality Act which includes age, disability, gender, marital status, race, religion and sexual orientation was not gathered by the provider. This meant the service could not ensure people were not discriminated against.
• Relatives and people told us staff were kind and caring. People appeared comfortable in the company of staff. We observed staff laughing and joking with people. One person told us, "They are lovely lasses, they work hard."
• Staff were extremely busy. Staff engaged with people in passing and when supporting people. They did not have time to sit and spend time with people. One staff member told us, "I wish we had more time to sit and chat but we just don't." Another staff member said, "We struggle to get everything done. I would love time to chat."
• A healthcare professional told us staff knew people well and they had no concerns. Two staff we spoke with were unable to tell us about people they were supporting. However, most staff we spoke with had good knowledge about people's needs and their preferences.
• Staff told us how they promoted people's independence. One staff member told us, "I encourage the person to do as much as they can themselves; never, never take over."
• People told us they were treated with dignity and respect. Staff knocked before entering people's rooms and asked permission before offering support.
• People's confidential information was not always kept safe. People's daily records and care monitoring information was held in a cupboard without a lock which people could access. On the second day of inspection we found the cupboard had been tidied but people's records were still left there.

Supporting people to express their views and be involved in making decisions about their care.
• Some care records did not show if people and their relatives were involved with in decisions about their care.
• The manager had introduced relatives' and residents' meetings and the provider had plans to gather additional feedback via questionnaires.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. One regulation had not been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.
• Care records did not always reflect people's current needs and preferences. Care plans we reviewed held incorrect information or had important information missing. Regular reviews were not carried out. This meant staff did not always have up to date information on how best to support people and their preferences.
• Information about people, including their life history, medical history and allergies was missing.

The failure to ensure care plans reflected people's current needs and preferences is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had recognised the issues with people's care plans and a plan was in place, with the manager receiving support from a registered manager and deputy manager from another of the provider's services to address the matter.
• People were encouraged to take part in activities, including art and craft, keep fit and a range of games. The service also arranged for entertainers to attend. We observed people enjoying a singalong. We noted there were limited activity options available for gentleman and people cared for in bed.
• 'The little onions', a group of children from a local school came once a week and looked after the garden area.
• A Falklands War veteran was an ambassador for the provider and regularly visited the service and chatted with people.
• People were supported to maintain their religious beliefs, with church services taking place.

Improving care quality in response to complaints or concerns.
• The provider had processes and systems in place to investigate complaints.
• Relatives and people were confident concerns and complaints would be dealt with appropriately. One relative told us, "If I had any problems I would see the manager."

End of life care and support.
• People's care plans detailed when a 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive was in place. These were monitored and reviewed when required.
• People had the opportunity to discuss their future care wishes.

Requires Improvement

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care.
• The manager did not have robust oversight of the delivery of care and support provided by the service.
• Information gained from reviewing accidents and healthcare professional's advice was not always adopted into people's care plans. Medicines were not managed safely. People at risk of malnutrition were not always receiving their appropriate treatment.
• Service quality audits were not regularly carried out by the manager. A compliance audit was completed in December 2019 and identified many of the issues we found during our inspection. An action plan was in place to address the matters, with a timeline, however, these were not always achieved and the issues were still evident during our inspection.
• The provider was introducing a new governance system and providing additional experienced staff to address the concerns and to support the service.
• Record keeping was poor across the service. Documentation relating to people's care and support was not complete, with gaps in recording, including positional changes and food and fluid monitoring. Calculations in people's tissue viability records and weight records were not always accurate which meant some people did not always receive the appropriate support and care.
• Following the inspection, the provider advised people's care records were being monitored daily. We reviewed care records provided by the service and found information continued to be missing and inaccurate.
• People's information was not always stored securely. The manager was unable to provide all the documentation we requested and was unable to give an explanation regarding its loss.
The lack of oversight of records had resulted in a failure to assess, monitor and mitigate risks to the health and wellbeing of people using the service.
These concerns demonstrate a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17. Good governance.

• During the inspection we found specific, serious concerns in relation to safe care and treatment, including medicines and good governance. On 20 March 2019 we sent a letter of serious concern to the provider. We requested assurances that the issues we identified were addressed. On 21 March 2019 we received an action plan from the provider outlining their intended actions.
• On reviewing accidents and incidents, we found two serious injuries that had not be notified to the commission.

Planning and promoting person-centred, high-quality care and support with openness; and how the

provider understands and acts on their duty of candour responsibility.
• The provider acknowledged, and was responsive, to our findings and provided action plans immediately following each day of the inspection.
• Staff told us team meetings were regularly held. The provider had carried out a survey with staff following the inspection.

Working in partnership with others.
• The provider worked in partnership with people's local authorities, multidisciplinary teams and safeguarding teams.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users was not always appropriate, did not met their needs or reflect their preferences. Assessments were not always completed. 9(1)(3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not always follow the principles and codes of conduct associated with the Mental Capacity Act 2005. 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the safe management of medicines and failed to respond or take action to mitigate identified risks. 12(2)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs

Treatment of disease, disorder or injury	The provider failed to ensure the nutritional and hydration needs of service users was met. 14(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems to assess, monitor and improve the quality and safety of the service. 17(2)(a)