Whittington Care Limited

Whittington Care Home

Inspection report

40 Holland Road
Old Whittington
Chesterfield
Derbyshire
S41 9HF

Tel: 01246260906

Date of inspection visit:
09 August 2022

Date of publication:
27 September 2022

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Whittington Care Home is a nursing home providing regulated activities personal and nursing care to up to 48 people. The service provides support to older people, including those with dementia. At the time of our inspection there were 28 people using the service. People's bedrooms were located on two of three floors. The home has communal lounges and dining spaces, a conservatory and a secure outdoor space.

People's experience of using this service and what we found
Although people's needs were assessed and reviewed, the guidance within people's care plans for staff to follow was not always reflective of their current needs. Some areas within the service were not cleaned to a high standard.

Governance systems were not always in place, reliable or effective in identifying issues. The provider did not ensure people were fully supported to feed back into the running of the service. Improvements were required to ensure people were consistently supported to achieve good outcomes. Staff felt supported in their roles and listened to by the manager.

There were enough staff to meet the needs of people using the service. Whilst the service regularly used agency to ensure safe staffing levels, consistent staff were requested which allowed people to build relationships with familiar staff. People were kept safe from the risk of abuse and staff had received up to date training in safeguarding. Lessons were learned from safeguarding concerns, accidents and incidents which were also shared with staff. Medicines were managed safely.

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 and update
The last rating for this service was inadequate (published 4 March 2022).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of a regulation.

This service has been in Special Measures since 3 December 2021. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected

We carried out an unannounced comprehensive inspection of this service on 20 October 2021 which was published on 4 March 2022. Breaches of legal requirements were found.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe and well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Whittington 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. 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
This inspection was carried out by two inspectors, a specialist nurse advisor and an Expert by Experience. 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 Care Home 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 Care Home 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 service 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. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a new manager in post, and they had started the process of registering with CQC.

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 and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with five people who use the service and seven relatives. We spoke with 10 staff, including the manager, clinical lead, nurses, care staff, domestic assistants and the cook. We carried out observations in communal areas. We reviewed a range of records including eight people's care records, some medicine records and some records relating to the management of the service.

Requires Improvement

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 inadequate. At this inspection the rating has changed to requires improvement. This meant 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.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- Care plans were not always reflective of people's current needs. Whilst they were regularly reviewed, care plans were not always updated when people's needs changed. For example, one person's care plan said they were weight bearing, but this was out of date as reviews noted the person was now hoist transferred. We found no one had come to any harm and staff we spoke with understood people's needs, but this increased the risk of people receiving inappropriate care.
- The service was in the process of re-writing all care plans to ensure they were reflective of people's current needs. There was a system in place which prioritised which care plans would be re-written next. For example, someone who had recently been assessed as having nursing needs was next due to this significant change in their care needs.
- People's weights were monitored. Where concerns were identified, appropriate action was taken such as referrals to dietician or speech and language therapists. Some people required modified diets; we saw staff practice reflected the guidance written in their care plans, such as thickening drinks to the correct consistency.
- People were supported to maintain skin integrity. People who were at risk of sore skin were assessed and monitored. When people had experienced pressure sores, documentation showed appropriate action was taken to address this.
- Regular maintenance checks were completed to ensure the environment was safe. This included regular fire safety checks. We reviewed personal emergency evacuation plans for people using the service and found these to all be in place to support safe evacuation in the event of an emergency.

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.

Using medicines safely

● Topical medicines were not always given as prescribed. We reviewed topical medicine administration records (TMAR's) for some people who were prescribed creams and found staff had applied them more often than the prescriber stated. We found no one had come to any harm as a result of this, however this had not been identified by the provider's quality assurance checks.
● Medicines were stored safely. For example, the treatment room was locked when not in use and we found medicines were in date and stock was accurate
● Regular checks of oral medicines were undertaken. The manager told us nursing staff were reviewing medicine administration records (MAR's) after each shift. This meant any errors were quickly identified and acted on.

Staffing and recruitment

At our last inspection staffing levels were not sufficient to meet the needs of the people using the service, placing them at risk of harm. This was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18(1).

● There were enough staff to meet the needs of people safely. A dependency assessment was regularly completed which informed how many staff were required. We reviewed rotas which showed staffing levels were in line with the dependency assessment. During our inspection the number of staff on duty was in line with the rota.
● Staff told us whilst generally staffing had improved, the home was often relying on agency staff who were not always familiar with the home or people. The manager told us they tried to use the same agency staff to ensure consistency and they were recruiting more care staff.
● People who required one to one support received this as commissioned. We observed one member of staff providing one to one support during our inspection. The staff member told us, "It's been really positive for [person], they are far more settled, eating and drinking more." We reviewed the observation record for this person which confirmed they were regularly receiving this support.
● Relatives observed sufficient staffing levels. One told us, "There are plenty of staff around and they have plenty of time to give attention to the residents." Another said, "The ratio of staff to residents seems to be good. We are familiar with some of the staff who were there six years ago. It's a good indicator if staff are staying."
● Staff were recruited safely. We reviewed three staff files which showed appropriate checks were completed prior to staff starting employment. This included a full employment history and explanations for any gaps as well as Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure that people were protected from the avoidable risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● People were safe from the risk of abuse. The provider had an up to date safeguarding policy in place and we saw safeguarding information was visible around the service. People told us they felt safe at the home, one person said, "I feel safe yes, but I would let someone know if not."
● Staff understood when and how to raise a safeguarding concern. We reviewed the homes training matrix which showed staff had received up to date safeguarding training. One staff said, "Training has increased we've done a lot over the past few months, safeguarding included."
● Safeguarding concerns were reported to the local authority when required. The manager proactively completed their own investigations which meant prompt action could be taken to keep people safe.
● Lessons were learned when things went wrong. The manager took action as a result of investigations into accidents, incidents and safeguarding concerns to prevent further risk. For example, following increased moving and handling concerns the manager sourced extra training for staff.
● We were unable to review all accidents and incidents, due to the provider not renewing the subscription used to previously log accidents and incidents. The manager told us as the subscription would not be renewed, a new system to oversee accidents and incidents within the service had been implemented which we saw would identify themes and trends to help mitigate risk and prevent further incidents.
● Safeguarding, incidents and accidents were routinely discussed at provider meetings. Learning was shared with staff to improve safety. For example, the home had weekly clinical risk meetings.

Preventing and controlling infection
● Some areas of the service were not cleaned to a high standard. This was due to areas within the building needing refurbishment. For example, we saw old stained carpets on the stairs which the manager told us they could not clean effectively and needed replacing. This increased the risk of infection to people.
● Soiled laundry was temporarily stored in communal toilets which we found to cause a strong odour. This was due to a dryer being out of order and impacting how quickly people's clothing could be washed. The manager assured us this issue was resolved the day after our inspection.
● 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 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.

Visiting in care homes
The service was supporting people to receive visits in line with current government guidance.

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.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider failed to maintain a reliable system to monitor accidents and incidents within the service. The provider did not renew their subscription to the system previously used, meaning all accidents and incidents up until six weeks before our inspection were unavailable on the day of inspection. This meant they could not be reviewed to ensure appropriate action had been taken to keep people safe. The manager told us they have asked the provider to retrieve this information and implemented a new system to monitor accidents and incidents.
- The providers governance systems were not always effective in identifying risk. For example, audits failed to identify topical creams had not been applied as prescribed. There were no systems in place to audit pressure cushions, we found one pressure cushion to be worn and stained during our inspection which had to be disposed of.
- The provider had no refurbishment plan in place despite improvements within the environment being required. Whilst the provider told us their focus was on safety and decluttering the home, there were no plans in place to address people's bedrooms and living spaces which we observed to be tired and run down.

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

- The provider did not always ensure the culture within the service was person-centred. For example, the main lounge area was locked on one side which meant people could not access this part of the building without staff support.
- People were not always supported to achieve good outcomes. For example, one person using the service told inspectors they did not have a call bell in place and to get staffs attention they would need to step onto a sensor mat which could cause them to fall. Systems had failed to check people had call bells in place. We fed back to the manager who ensured call bells were in place for everyone who needed one immediately.

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

● People who used the service and their families were not provided with the opportunity to formally feedback. There were no resident meetings held or surveys sent out. This meant people who needed additional support to communicate any feedback had no involvement in the running of the service.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate effective oversight. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported by kind staff. We observed friendly interactions between staff and people during our inspection. People and relatives spoke positively about specific care staff who supported them.

● Regular meetings were held with staff. This provided opportunity to feedback, be involved in the running of the service and keep updated on current service issues. Staff told us they found these meetings helpful.

● Staff felt listened to. Staff satisfaction surveys were carried out. One staff said, "We now have a manager who listens to us and does what is best for everyone." Another told us, "[manager] is really good, she listens."

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 understood their responsibilities under duty of candour. We found them to be open and transparent throughout the inspection.

● The service had received one minor complaint the day before our inspection, whilst not yet managed through the formal complaint's procedure, the manager had already contacted the complainant to apologise.

Working in partnership with others

● The service worked collaboratively with a range of external stakeholders and agencies. This included the local authority, commissioners and health and social care professionals. The service sought advice and guidance where appropriate.

● Information and guidance from professionals was shared with staff through handovers. This ensured people using the service received consistent and appropriate support.

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 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to demonstrate effective oversight. This placed people at risk of harm.