Farrington Care Homes Limited

Whitway House

Inspection report

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Date of inspection visit:
10 June 2020
15 June 2020

Date of publication:
06 October 2020

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Whitway House Nursing Home is a residential care home providing personal and nursing care. The service can support up to 39 people. There were 24 people living in the service at the start of this inspection.

People's experience of using this service and what we found
People were at risk of harm because the systems in place to ensure they received safe and appropriate care were not effective. Risks were not assessed, and care plans were not in place to direct staff to provide safe care and treatment. Risk management systems in place were not implemented consistently.

Staffing levels had been changed without reference to the dependency needs of people living in the home. Staff told us that the levels were currently better but that this had been very difficult to manage.

People did not always receive health care in a timely manner.

Staff understood how to identify and report abuse and spoke with care about the people they supported. However, the systems in place did not ensure that allegations were responded to robustly and appropriately. This meant people were at risk because potential abuse was not adequately investigated.

The governance of the home was not sufficient. Policies were not implemented. Improvements identified in action plans were not always reflected in 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 January 2020)

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about staffing, risk management, responses to safeguarding concerns and access to healthcare. A decision was made for us to inspect and examine those risks.

CQC have introduced targeted inspections to follow up on a Warning Notice or other specific concerns. They

do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well-Led sections of this full report.

We have been told by the providers that action has started to mitigate omissions found, and that communication is improved between the acting manager of the home and the provider organisation. The acting manager sent through care plans they had completed following the inspection site visit.

Enforcement: 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 to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, safeguarding, and the oversight of safety and risk.

We varied the registration of the provider by removing regulated activities from this location. This meant the service was no longer registered. There were no people living in the home after 9 September 2020.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Whitway House

Detailed findings

Background to this inspection

This was a targeted inspection to check on specific concerns we had about safe care and treatment of people, access to emergency health care, staffing levels, safeguarding processes and the oversight of safety.

Inspection team
The inspection was carried out by two inspectors.

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

The service had a manager registered with the Care Quality Commission. This manager was no longer employed at the service but they had not cancelled their registration. The manager that had replaced them in January 2020 left the service the week before our visit. A registered manager 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
This inspection was announced. We announced the inspection the day before we visited to discuss the safety of people, staff and inspectors with reference to Covid 19.

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 had not requested the provider send us a provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We had been receiving monthly reports from the provider that gave us this information.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke

with three care staff, two nurses, a housekeeper and the activities coordinator. One of the nurses was the acting manager of the home. We also spoke with social care professionals involved with the service.

We reviewed a range of records. This included four people's care records and a medication record. We looked at three staff files. We also reviewed a variety of records relating to the management of the service including rotas and policies and procedures.

After the inspection visit.
We continued to seek clarification from the provider to validate evidence found. We spoke with the service's nominated individual and two further representatives of the provider on 15 June 2020. The nominated individual is responsible for supervising the management of the service on behalf of the provider.We received evidence from the providers and staff until 15 June 2020.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Inadequate. This meant people were not safe and were at risk of avoidable harm. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check specific concerns we had about risk management, safeguarding and staffing levels. We will assess all of the key questions at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure that effective systems were in place to ensure allegations of abuse were responded to. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) 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 13.

- The provider had safeguarding systems in place and staff told us they knew how to identify and report abuse. However, these systems were not always followed effectively and were not sufficiently comprehensive.
- An allegation of abuse had been made to the manager in May 2020 by a member of staff. The manager did not raise an alert to the local authority safeguarding team, nor did they notify CQC of the allegation. This did not reflect the policy of the home. In a response to the local authority safeguarding team, the manager detailed actions taken to protect people from unsafe manual handling. There were no records to support that these actions had been taken.
- Allegations were made about the practice of the manager and these were shared with the providers by CQC. The home's policy did not make provision for this scenario. The providers asked the manager to investigate themselves. We discussed this with the providers, they told us that if allegations were made about a manager they would investigate, or they would ask another manager to investigate. They acknowledged that this did not happen.

This was a continued breach of Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 (Safe Care and Treatment) 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 12

● Risks assessments and associated care plans were not in place for some people. One person had moved into the home three weeks before we visited. Staff told us this person was at high risk of falls and a care plan had been written to support their mobility, without an assessment of their falls risk being completed to determine factors that impacted on their risk and to develop appropriate responses.

● A person who had moved in to the service three weeks before we visited did not have care plans written to describe the risks they faced. The initial assessment completed by staff at the service was not detailed and had not been signed or dated. The local authority assessment emphasised the risk of the person of eating and drinking things which were harmful to their health. No consideration of this risk had been undertaken. The person was at risk from wandering, especially at night. To reduce the risk a touch sensor mat was recommended; however, no assessment had been completed and the recommended sensor mat was not in place. The person also required support to maintain a healthy weight and dietary intake. However, there was no nutritional assessment or care plan in place to guide staff about the care and support the person required.

● This person had a wound, which a registered nurse said was found on admission. There was a wound care plan in place, but this did not direct staff about the frequency of dressing changes. Instructions said, "When required" or "as needed". The record of dressing changes showed a variation in the length of time between dressing changes; from four days to six days. The risks associate with pressure damage for this person had not be assessed to ensure the prevention of pressure ulcers.

● Following the inspection we were sent a copy of a care plan and risk assessments for this person. The care plan dated 12 June 2020 did not respond adequately to the risks this person faced. The person had just reached a safe weight but their was no reference to this in their care plan and no additional monitoring in place to ensure their safety. There was also no reference to them eating and drinking harmful substances or a known behaviour that could put them and others at risk. We were also sent risk assessments dated 26 May 2020. These had not been available in their records during inspection.

● Another person had a behaviour plan in place, dated 23 March 2020 and reviewed in April and May, that detailed what could happen when they were upset and anxious. This care plan did not reflect the home's policy that outlined that all incidents of aggression towards staff must be recorded and reflected in their care plan. Care staff consistently told us how they responded to this person when they were agitated, this included a technique not described in their care plan. Staff described times in the two months prior to our inspection when this behaviour had occurred. The person's behaviour record had not been completed since 15 February 2018. The care plan was not sufficient, and recording did not enable changes to the care plan. This put the person at risk of inappropriate care.

● This person was identified as diabetic and they did not have a care plan to describe the way their diabetes impacted on them or how to reduce any risks. We asked the acting manager about this and they told us that they were not sure if the person was diabetic. The person was at risk of inappropriate care and treatment because their health needs were not adequately assessed or planned for.

● Staff did not regularly refer to care plans and said they had not seen care plans for people recently admitted to the service. They relied on information from handover or other staff when delivering care. This posed a risk of people receiving inappropriate care.

● Risks associated with COVID 19 had not been adequately addressed. The home had a COVID 19 policy provided to CQC on 29 May 2020. The policy referred to the use of a nursing tool to be used to monitor any deterioration in people's health. We spoke with two nurses who did not know what this tool was, or how to

implement it.
● Competency assessments had not been undertaken with two staff following allegations about poor manual handling practice. This meant it was not clear that some staff the skills they needed to provide this support to people safely. Staff told us they were confident with their ability to support people to move safely. They told us they had the equipment they needed.
● One nurse who was in charge of the home when they worked had not competed Infection Control or COVID 19 training.
● Information held for the emergency services at the entrance to the home had not been updated to reflect the rooms people were in and a hospital admission. This put people and emergency services personnel at risk should the information be required in an emergency.

There was a continued breach of Regulation 12 Safe care and Treatment of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

After our inspection the acting manager of the home informed us that the care plans and risk assessments would be carried out, written and reviewed as appropriate.

Staffing and recruitment
● The number of people living in the home since our last inspection had reduced and staffing levels had also changed. Following concerns raised about staffing levels in the home, we asked the manager to provide information related to people's dependency needs. Discrepancies in the dependency tools provided to CQC during our inspection indicated that the staffing was not being determined by the needs of people living in the home as outlined by the home's policy. We spoke with the providers about this and they told us they worked out staffing based on the staffing levels in their other homes and then altered these based on what managers told them. They told us they gave the home a set number of hours and it was up to the manager to determine the rota. They told us they did not look at completed dependency tools when determining the staffing budget.
● The nurse hours were reduced from two nurses on shift in the day to one nurse on 13 April 2020. On 18 May 2020 care staff were reduced from five carers to four carers with an extra carer for part of the day 3 days a week. It was not clear why these changes happened at these times. This staffing level remained during a time when new people with high support needs moved into the home. Staff referred to this time as 'very difficult' and told us that people's care needs were met but they had to rush and did not have time to chat with people. This was reflected in the comments made by a person we spoke with who told us, "I don't want to call staff as they have enough to do."
●The manager and provider decided to increase staffing to provide an extra care staff on shift when they provided the second dependency tool to the local authority on 29 May 2020. They explained this was to meet the needs of a person who had moved in a week before this. Care staff felt that having a fifth care staff returned to shift had improved the situation.
● During our visit staff told us staffing had been difficult for a number of reasons. A nurse told us they were very busy with one nurse to 22 people with nursing needs at the time of our visit. Cleaning staff told us they no longer had time to do deeper cleaning such as shampooing the carpets in communal areas. Activity staff had found visiting isolated people more difficult as they had to stay and supervise communal areas for safety when care staff were supporting people with care needs.
● We noted employment checks were not robust for one member of the care team. The manager brought other files of recently recruited staff to show that this was not usual practice.

Preventing and controlling infection

● Staff had access to PPE and the home was kept clean during our visit. We discussed the face masks available as some staff had difficulty keeping them up and they required constant repositioning. The manager told us the next day that they were trying masks with ties to address this difficulty.
● The reduction in cleaning hours resulted in housekeeping staff having less time to carry out deep cleaning schedules in order to prevent and reduce the potential transmission of the virus by touch.

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.

At the last inspection this key question was rated as Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check specific concerns we had about access to health care. We will assess all of the key question at the next comprehensive inspection of the service.

At our last inspection the provider had failed to ensure people received safe care and treatment by ensuring they had access to health care when needed. This was a breach of regulation 12 (Safe Care and Treatment) 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 12

Supporting people to live healthier lives, access healthcare services and support

● A person living in the home had not received timely access to healthcare. Records indicated they showed symptoms that they may have needed emergency health care. Initial assessments were poor and incomplete. Records stated the person's condition should be "observed". However, there were no records of observations or monitoring of the person's health during the day (for nearly nine hours), which may have alerted staff to their changing health needs. The person's care file contained a nationally recognised physical deterioration and escalation tool for care or nursing staff to complete. This record was blank. Two registered nurses were not aware of the tool or how to use it. This meant staff may have missed an opportunity to obtain medical advice for the person in a timely way.

Inadequate

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 the last inspection this key question was rated as Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check specific concerns we had about the oversight of safety in the home. We will assess all of the key question at the next comprehensive inspection of the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had failed to ensure that oversight was effective in improving the safety and quality of the care people received. 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.

● The providers did not have effective governance systems in place to ensure continuous improvement. The providers had appointed a consultant to assist with improvements in the home. The consultant had provided an action plan. The implementation of the action plan had not delivered sufficient improvements to the safety of people's care and treatment.
● Auditing and governance systems had not always identified or addressed the concerns raised during this inspection. Audits had not identified that care records did not contain a care plan to meet a person's health condition. Oversight had not identified that there were no care plans in place for another person. A further person had no risk assessments in place and oversight had not highlighted this.
● Policies did not determine practice in the home. The providers had not followed the staffing policy in the home and had not used information about people's dependency needs to determine the homes budget. The acting manager provided us with an out of date policy folder when first asked for policies. The policies relating to people's behaviour when they were upset were not followed. The policy on quality assurance we were provided was dated June 2020, however it referred to a statutory framework that ended in 2014.
● Information in the action plan provided to CQC in response to conditions imposed on registration was not reflected in practice. For example, the action plan stated that handover notes were now an accurate reflection of people's needs and that care staff reported concerns about people's welfare in their care delivery notes. We found this was not consistently the case.
● Information provided to CQC was not always accurate. An email to providers, including the Nominated

Individual, from the manager included a dependency calculation described as "a realistic dependency score which is not for CQC" this described 22 people as having high dependency needs. The email also included a dependency calculation that indicated eight people had high dependency needs. The providers sent CQC the tool indicating lower needs. We asked the provider what they had done in response to receiving different information, they told us they do not look at dependency tools. People were not protected from varying staffing levels as the provider did not determine staffing levels according to the needs of people living at the service.

- The lack of information for staff in relation to meeting people's needs had not been identified through a quality monitoring system. This meant that appropriate action was not always being taken to prevent harm to people who had changing health needs or needs relating to nutrition, pressure damage or behavioural issues.
- The records kept in the home were not sufficient to monitor safety. Care records did not reflect a person being distressed when staff said they had been. Rotas and time sheets did not always tally so it was not always possible to tell who had been working. It was not possible to tell from rotas and signing in sheets that staffing was increased when the local authority were told it was.
- CQC had not received notifications related to the allegations of abuse.
- The previous manager was still registered with CQC. The provider had not ensured that they had applied to cancel their registration. This is important because registered managers had legal obligations.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were not protected from risks to their health and welfare due to failures to identify, assess and monitor relevant information. Plans were not always in place to reduce risk. Regulation 12 (1) (2) (a)(b)(c) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We varied the registration of the provider and removed regulated activities at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment
	Allegations of abuse were not identified and responded to effectively. Regulation 13 (1) (2) (3) (Safeguarding Service Users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We varied the registration of the provider and removed regulated activities at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Failures of oversight had resulted in risks not being identified or acted upon appropriately. Recording was not accurate or complete. Regulation 17 (1) (2) (a) (b) (c) (d) (ii) (f) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We varied the registration of the provider and removed regulated activities at this location.