Farrington Care Homes Limited

Whitway House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Whitway house was last inspected on 4 December 2013 where it was found that medicines were not administered safely. The provider wrote and told us that they had made the necessary improvements with medicines management.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Whitway House provides care and support for up to 39 older people. At the time of the inspection there were 37 people living at the home.

The leadership within the home needed to be improved. The provider did not have an effective system to check the quality of care people received at the home. Peoples individual care records were not always complete and the systems in place to evaluate and improve the care being given were not robust.

The systems and procedures for handling medicines were not safe and improvements were required. The system in place for the auditing of medication required improvement as it had not identified areas that needed improvement.

Care records were not always accurate and reliable. Where people said they needed assistance to achieve certain outcomes they we not supported to do so, care records did not consistently record these wishes.

People's care records were not kept in a safe and confidential manner. During the inspection we noted people's personal records were left unattended in communal areas.

People were able to raise concerns with the staff who in general terms took action to resolve the presenting issues. One person told us about how they were able to negotiate a different room when they were unhappy sharing. However, when a person expressed a wish to live somewhere else they provider had not responded appropriately.

People told us the staff were kind and caring and supported them in a caring way. One person told us "if I ask for help there is always someone around, they are patient with me when I want to do things myself" another person described the staff as "very kind to me". A visiting relative told us about how kind and compassionate staff were.

People and their relatives were given information about the running of the home and how they could comment on areas for improvement.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. The medicines administration was not consistently safe at the home. The auditing of medicines could not be robustly carried out as the amount of medicines received into the home were not always recorded.

Some people had risk assessments and care plans to keep them safe but not all. Where risk were acknowledged there was not always guidance for staff to protect people from the risk of harm that could be avoided or minimised.

Staff were not consistently clear about who to report safeguarding concerns too. There were sufficient staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective at meeting people's needs and improvements were required. People were at risk of not having their legal rights acted upon as they had not always consented to the care and treatment they received.

People were not consistently supported to eat effectively and safely.

People could not be assured that they would be cared for by suitably trained staff.

People had access to health and social care professionals when required.

Is the service caring?

Requires Improvement

The service was not consistently caring and improvements were needed. Peoples personal care records were not kept safe or confidential.

Staff did not always demonstrate that they treated people with respect and dignity.

Some people could make individual choices about how they spent their time but not all.

Is the service responsive?

Requires Improvement

The service was not consistently responsive to people's needs. Care plans were in place but these did not provide sufficient information for staff to meet people's needs consistently.

When people wished to be enabled to fulfil their wishes the service did not consistently look for ways to achieve this.

Activities were provided on a daily basis

People knew how to raise concerns. Staff knew how to respond to complaints if they arose.

Is the service well-led?

Requires Improvement

The service was not consistently well led. The system to ensure the quality of the service was reviewed and improvements made was not effective at driving standards up.

Staff confirmed the registered manager was approachable and they felt listened too.

Whitway House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 and 15 of December 2015 and was unannounced. The inspection was completed by two inspectors.

Before the inspection we reviewed all the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about and feedback from relatives. At the time of the inspection a Provider Information Record (PIR) had not been requested. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We were able to gather this information during our inspection. In order to gain further information about the service we spoke with seven people living at the home and two visiting relatives. We also spoke with seven members of staff.

We looked around the home and observed care practices throughout the inspection. We reviewed six people's care records and the care they received. We looked at people's medicines administration records, (MAR). We reviewed records relating to the running of the service such as environmental risk assessments, fire officer's reports and quality monitoring audits.

We contacted two health care professionals involved in the care of people living at the home to obtain their views on the service. We also spoke with visiting opticians who were supporting people at the home

Observations, where they took place, were from general observations. We also 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.

Requires Improvement

Is the service safe?

Our findings

Medicine management was not consistently safe. We observed, in the locked medicines room, that medicine that should have been stored in a dedicated medicines fridge was on a work top in the first floor treatment room at 10 o'clock. This was still on the work top unmoved at 11.15am. The temperature of the treatment room was 27 degrees centigrade (based on the provider's thermometer within the room) although the temperature of the locked medicines room was checked at intervals throughout the day. We looked at five medicines in the medicines trolley and noted that three had storage instructions stating that the medicine must be stored below 25 degrees centigrade. The staff were unaware of this issue until this was pointed out to them and took action to reduce the temperature in the room.

We looked at the Medication Administration Records (MAR) in use at the time which showed that when medicines arrived at the home the staff did not consistently record the amount of medicines that the home received. This meant that it was not possible to carry out an audit of the medicines administered and undermined any systems that the provider had for ensuring medicines were administered as dispensed.

We noted that people were prescribed medicines on a 'required need' basis. People's MAR contained a separate sheet that gave brief instruction as to when it was permissible to give these medicines but this system to ensure medicines were not given inappropriately were not being consistently used. An example of this was that one person was being given medicine routinely that was prescribed to be given when they experienced pain or anxiety. Staff giving the medicine told us that the medicine should be given routinely. There was no record that the person was in pain or anxious when it was. We spoke with care staff who told us that they responded to the person's anxiety by either spending time talking with them or leaving them for a very short period and then going back to support them. We looked at the recorded audit of medicines administration that did not evidence that the above issues had been identified. This meant that people may receive medicines prescribed on a 'required needs' basis inappropriately.

We spoke with the registered manager about our concerns over this issue. They told us that the instructions allowed for giving this medicine 'as required' but would telephone the prescriber for some clarity on this issue. Later in the day the registered manager told us the prescriber confirmed they were happy with the way the staff were administering this medicine.

One person, who had recently moved in and was sharing a room with another new person, had been assessed as posing a risk to others due to 'inappropriate behaviour'. Their care records stated that they can become upset with new or different surroundings. There was no risk assessment to protect staff or others from inappropriate behaviour or a description of what the behaviour was. There was no consideration given to the risks that sharing an unfamiliar room with a person they had never met might be.

The above illustrates a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were unclear as to who to report abuse or concerns to. We spoke with staff about who they would

report concerns. Whilst all were clear that they would report their concerns to either senior staff or the registered manager when we asked who they would report concerns about the register manager only the senior staff member could identify where to find the home's policy on abuse. This senior staff member responded to our question of managerial concerns by saying "If someone told me about (concerns with) the registered manager, I would tell them they must be mistaken as the manager would never harm anyone", this demonstrated a lack of understanding in the responsibility individuals have to protect vulnerable people. There had been one safeguarding concern that had been reported to the local authority. There was evidence that the registered manager had worked with the local authority to resolve the issues.

People told us there were sufficient staff to meet people's needs. We spoke with staff who told us that sometimes were busier than others but there was always enough staff to help out. We looked at the staffing rotas that informed there was usually seven to eight staff on duty to meet people's needs during the day and four staff at night.

The people who could told us that they felt safe living at the home and in the company of the staff.

Requires Improvement

Is the service effective?

Our findings

Mental capacity assessments were not meeting the requirements of the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had made arrangements for people's capacity to make decisions to be assessed when there were concerns identified. However, applications to deprive people of their liberty under the Deprivation of Liberty Safeguards (DOLS) had not been consistently made. An example of this was one person told us they no longer wished to stay at the home. Although they told us it was a good home they wished us to find out why they could not leave, as they wanted to live in their own home. We looked at the person's care records and could not find an application to the relevant authority to deprive them of their liberty had not been made or MCA documentation. We spoke with the registered manager who told us the person often says they want to leave only to retract it later. They also told us the person's social worker was aware of this. This meant that whilst staff and professionals were aware of the person's wishes a DOLS application had not been made which meant the person was at risk of having their liberty restricted unlawfully. Following the provider receiving the draft report the registered manager told us that an application had been made in July 2015.

People who did not have capacity to make decisions did not consistently have a Best Interest Decision (BID)recorded when sharing a room with another person. An example of this was two people who had recently taken up residency were sharing a room. One person was judged to have capacity the other was not. This meant one of the people had capacity to decide for themselves if they shared a room. However there was no recorded BID for the person without capacity in relation to sharing the room with a previously unknown person. The registered manager told us that it was with the consent of the families that these two people shared a room but there was no recorded evidence of this.

Not all staff understood how the MCA effected how they support people. The staff confirmed they had received training in the MCA. We spoke with one staff about the MCA and their understanding of it. They told us "I think that's a management thing". Other staff were able to tell us more about how to support people with choices when they lacked capacity, some linked this to the MCA.

People were not consistently supported to eat effectively and safely. We observed one person being supported to eat their dinner whilst they lay down in bed. After a few minutes the staff member left the room and did not return. We observed the person trying to eat themselves, only giving up after they had knocked their drink over. We did not observe any further staff support and after 10 minutes we noted staff take away a half full plate of food. We looked at the person's care records which did not give staff guidance on how to support the person safely when eating. We spoke with the registered manager and informed them of our observations. They told us that the person should be sat up as much as was possible to avoid choking, we informed them this was not what we observed.

The above illustrates a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the food was good at the home and there were choices available. One person told us, "if I don't like something the staff will get something different, I eat as well here as I ate at home". Another person told us "I enjoy my food, I like what I am served as there is always plenty of it". We spoke with catering staff who told us that they provide vegetarian meals and special diets as required.

People could not be assured that they would be cared for by suitably trained staff. The training records of senior clinical staff demonstrated that whilst they had received updated training between 2014-15 they had not kept up to date with all of the training identified as necessary for the role they undertook. For example, the home provided end of life care yet only one member of the six clinical staff had received palliative care training in 2014 and one in 2012 and no clinical staff had received updated syringe driver training (to control pain in extreme case's) since 2012. The training records relating care support staff also evidenced that the core training set out by the provider had been provided in 2014 -2015 but only one member of staff had received training with regards to palliative care, dignity and respect, nutrition and food safety between 2012-2015 respectively. The registered manager could not reassure us that the rota was based on having the suitably trained staff on duty. When asked if the rota was organised based on staff skills and experience we were told by the registered manager it was not as there were problems with maintaining staff levels.

People told us that if they needed to see a doctor, or specialist, the staff made arrangements on their behalf. We looked at people's care records which evidenced that health care professionals came into the home to support people. The home had an arrangement with the local GP to provide a service to the people who lived at the home. The staff told us that the GP came in and held a surgery to support people who staff had concerns about. They also provided emergency call out cover if required. We spoke with a visiting optician who supported people living at the home. They told us that they worked closely with the home to offer this service and informed us that staff always contacted them if they had concerns that they could help with.

Requires Improvement

Is the service caring?

Our findings

Peoples care records and daily observation records were not kept in a confidential manner. On both days of the inspection we noted that some people's care and daily records we left unattended in communal areas, on table tops in the downstairs dining room, in corridors and in communal sitting rooms. These records contained information that was private and personal to the individuals. As visitors to the care home had unrestricted access to these areas this meant that people's right to privacy was not being respected. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we asked visiting relatives if their views had been sought about the provision of care. One relative told us they "the home cared for my relative, they were brilliant very caring and compassionate, I so glad they (relative) came here." Another relative confirmed that staff spoke with them about their loved one and knew some of the contents of their care plan.

People's care records did not consistently evidence that people had been consulted about their care. Whilst care records described some of the tasks that people required help with there was little guidance about people's individual routines and how they wished to be supported in an individual manner. Some staff were able to talk to us about people's individual routines and how they offered choice of what to wear for example. Staff also told us about how they supported people when they became distressed such as sitting and talking with them or supporting them to different locations in the home to avoid stressful situations. People's care records did not always reflect the staff knowledge of the people they supported. Whilst what we were told by staff represented a caring approach to the work that they do we did not consistently see these approaches put into practice.

People were not consistently treated with compassion. We observed one person who became distressed because they had dropped their spoon whilst eating their dinner. They apologised profusely to a member of care staff. The member of care staff did not respond to their unwarranted apology and did not reassure them that it was ok and went and got a clean spoon, gave it to them and walked away. It was not until another member of staff intervened and gave the person some reassurance that it was "just an accident and no problem" did the person return to eating their dinner.

People told us the staff were kind and caring. We spoke with people who could tell us how they experienced care. One person told us about how the staff supported them in a caring way. They told us "if I ask for help there is always someone around, they are patient with me when I want to do things myself" another person described the staff as "very kind to me" and "the girls (staff) are always about, they help me dress and wash, they are very gentle". We observed some care practices that reflected what people told us. We observed staff holding people's hands and talking with them and some staff reassuring and encouraging people.

Requires Improvement

Is the service responsive?

Our findings

People's care plans did not contain sufficient guidance for staff to support them responsively. An example of this was that we observed one person who was being cared for in bed. We spoke with them about how they experienced care. They told us "the staff are very busy and don't have a lot of time to talk". We looked at their daily care records which informed that they were repositioned in bed but the records evidenced a random pattern of repositioning. We looked at their care plan in relation to frequency of repositioning but this did not offer any guidance to staff on this issue. We spoke with senior staff who were responsible for running the shift who told us the person requires repositioning every two hours. We asked where we could find the guidance to staff; they told us all those people that require repositioning have this support every two hours.

As the daily care records did not evidence this was happening at this frequency and as failure to reposition may led to an increased risk of skin damage, we raised our concerns with the registered manager. They told us that the person requires repositioning to make them comfortable when required and that they have pressure relieving equipment to reduce the risk of skin damage. They told us the staff repositioned the person when they wished but this was not clear in the care records. This meant that there was not a common understanding between staff about how to support the person and no guidance in the care records.

We spoke again with the person about how they summon help. They told us they waited until staff come in and then ask. We noted they had a call bell, to summon help, and asked if they could use it, they told us "not really". During the inspection we assisted the person to summon help as they could not use the call bell and required assistance. This meant that the person could not summon help when required, as described by the registered manager, and the staff did not have guidance on the frequency to check the person was safe and comfortable.

The person told us that they wanted to be with other people and would like to get up and go downstairs. We spoke with staff who were aware of this wish but told us that the person was in too much pain to move them. When speaking with the registered manager they further confirmed that the pain the person was in prohibited them from getting out of bed. However there was no recorded evidence that a health professional had been consulted who may have been in a position to provide advice and guidance on moving the person safely and with little pain.

The above illustrates a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people about how they resolved individual concerns. One person told us about how they were unhappy sharing a room and how staff had listened to them and arrange for a new room to be allocated. They told us "I explained that I did not wish to share to the (registered) manager and as soon as a room became available I was supported to move". Another person told us that they did not like to have too much food at lunch times and that following telling staff this they now only received small portions.

People told us they were provided with activities through the week. One person told us about going out but could not remember when but informed us they enjoyed going out. The provider had employed an activities coordinator who provided things for people to do and visited people who were cared for in bed. We observed this staff member working with groups on both days of the inspection. The people living at the home appeared to enjoy this stimulation.

Requires Improvement

Is the service well-led?

Our findings

Care records had not been audited to provide an overview of the support people received to ensure the care provided was as stated. We asked the registered manager when people's care records were audited to ensure people's needs were met in a consistent manner and to ensure good quality care. The registered manager told us they will do a full audit of care records at the end of year. They also told us that people's care records were reviewed monthly by senior staff and felt this was sufficient. As senior staff were also responsible for writing plans of care this meant that the reviewing of the quality of care was not robust as senior staff were checking their own work. There was evidence that this meant they missed issues such as dispensing of medication that was not in line with the prescribers instructions or but not giving staff clear guidance in relation to the issue of people who required repositioning and to support people safely.

The systems in place to audit medicines were not robust. Medicines audits were unreliable due to MAR not having sufficient information on them to carry out an audit reliably. We looked at 12 MAR, two of which demonstrated that when medicines were received into the home the staff were not recording the amount received. This made the system for auditing the medicines management ineffective.

The systems in place to ensure people were protected from harm through health and safety issues associated with the environment were failing. We looked around the premises and in people's rooms. We found that many of the heating radiators were extremely hot to touch, not all were guarded putting people at risk of harm through scolding. We looked at the provider's health and safety audit which did not identify this as an issue. We also looked at the provider's improvement plan in relation to the environment, this did not identify that radiator covers were needed to protect people from the risk of harm. This meant that not all of the risks people faced were assessed through health and safety auditing of the home.

The above illustrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that staff had recorded accidents and incidents. Where people had been involved in an incident or an accident, for example a fall, the staff recorded the cause, the injuries and the actions or treatment that had been delivered. These accident / incident records were checked by the registered manager, who assessed whether an investigation was required and who needed to be notified.

The provider had a plan to make improvements to the building and furnishings. We noted that many soft furnishing' needed replacing as well as communal carpets. Whilst the improvement plans recognised these areas of improvement there were no dates associated with the plan. This meant it was not possible to check the progress made in relation to the environmental improvement plan.

There was a management structure in place at the home. The register manager was supported by senior clinical staff who supported people with clinical needs. These staff were responsible for organising the staff on each shift. The clinical staff also had senior carers to support them in this role. Staff were aware of the roles of the registered manager and they told us they were approachable and available to discuss issues

most of the time.

The registered manager told us about initiatives that had started to build an effective team of staff. They told us they had recently taken on two apprentice careers that were being supported by all staff at the home. They told us that they considered the apprentice scheme was working well and giving new staff the opportunity to learn the care industry 'hands on' but also supported by class based training.

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 did not take formal enforcement action at this stage. 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 12 HSCA RA Regulations 2014 Safe care and treatment 12(f) (g) Medicines administration records were not accurate putting people at risk of harm. The storage of medicines was not safe. 12(2) (b) The acknowledged risks people faced were not consistently managed or action taken to minimise these risks.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 17(c) Care records were not accurate putting people at risk of receiving inappropriate care 17(a) Peoples care records did not demonstrate that care needs and practices were monitored to mitigate the risks relating to the health, safety and welfare of service users. Plans to make ongoing improvements at the home failed to consistently consider the delivery of care and support needs of the people living at the home.

The enforcement action we took:

Warning notice