Barchester Healthcare Homes Limited

Wykeham House

Inspection report

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Date of inspection visit:
06 April 2017

Date of publication:
08 June 2017

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?	**Inadequate**

Summary of findings

Overall summary

This inspection was carried out on 6 April 2017. Wykeham House is a purpose built care home providing nursing and residential care for up to 76 older people, some of whom are living with dementia. The service is separated into four units; two of the units are for people living with early to late dementia and the other two units are for people with greater nursing needs. At the time of our inspection there were 53 people living at the service.

There was a registered manager in post and present on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At our inspection in August 2016 we had identified a breach of regulation in relation to person centred care, dignity and respect, consent, safe care and treatment, the competency skills of staff, acting on complaints and lack of good governance. We issued warning notices in relation to the lack of competencies of staff and governance. The provider sent us an action plan in October 2016 that stated that they would meet these regulations by the 30 November 2016. However, we found at this inspection a systematic failure to identify and put right the shortcomings in the service as we found the warning notices had not been fully met and we identified further breaches of regulation.

People were not always protected from the risks of unsafe care. Risks to people had not always been identified and acted upon including risks around behaviours, lack of nutrition and bed rails. However there were other aspects to the risks to people that were addressed by staff including environmental risks. Personal evacuation plans were in place for every person and staff had received fire safety training.

Staff were not always suitably qualified, skilled and experienced to meet people's needs. This was particularly in relation to new staff and staff that did not have knowledge of people's needs. Staff however had received appropriate support that promoted their professional development and had regular supervisions with their line manager.

There were times where staff did not treat people with dignity and respect and choices were not always offered. However people's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. We did see times where staff were kind and attentive to people's needs.

People did not always have access to activities that were important and relevant to them.

The provider did not always have systems in place to regularly assess and monitor the quality of the care provided.

Complaints were not always investigated with the necessary action taken.

Although the provider actively sought, encouraged and supported people's involvement this was not always used to improve the quality of care. Although staff were encouraged to contribute to the improvement of the service staff did not always feel listened to or valued.

People's records were not always up to date or accurate. People's care plans did not always have the most up to date care needs recorded and food and fluid charts were not always completed accurately.

People told us that they felt safe and we found staff understood how to protect people from the risks of abuse. Recruitment practices were safe and relevant checks had been completed before staff started work. We found that there had been improvements made to staffing levels and there was now sufficient numbers of care staff deployed at the service to meet people's needs.

Staff understood how to support people to make decisions. Where people had restrictions placed on them there was evidence that these were done in their best interests. Staff had a clear understanding of Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) and their responsibilities in respect of this.

On the whole people had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk. People were given choices of meals. People were supported to have access to healthcare services and were involved in the regular monitoring of their health. The provider worked effectively with healthcare professionals and was pro-active in referring people for assessment or treatment. Medicines were managed safely and people received their medicines when they needed. Staff competencies with medicines were assessed.

People's needs were assessed when they entered the service and on a continuous basis to reflect any changes in their needs. Care plans showed that people and relatives (where appropriate) were involved in the planning of their care.

People told us the staff and management were friendly and approachable.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Well-led for this service is rated as 'Inadequate' and the service therefore has been placed in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this time frame. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service.

This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

People did not always have risk assessments based on their individual care and support needs. However people were protected from environmental risks.

Medicines were administered, stored and disposed of safely.

There were sufficient staff at the service to support people's needs.

Recruitment practices were safe and relevant checks had been completed before staff commenced work.

There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by staff that had the necessary skills and
knowledge to meet their assessed need. However staff did receive clinical training and supervisions.

Staff understood how to apply legislation that supported people to consent to treatment. Where restrictions were in place this was in line with appropriate guidelines.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk.

People were supported to access healthcare services and healthcare professionals were involved in the regular monitoring of people's health.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treat people with dignity and respect. Support was not always provided in accordance with people's wishes. However we did see occasions where staff were kind and attentive towards people.

People's preferences, likes and dislikes had been taken into consideration.

People's relatives and friends were able to visit when they wished.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always have access to activities that were important and relevant to them.

Complaints were not always investigated with the necessary action recorded and responded to.

People's needs were assessed when they entered the home and on a continuous basis.

Is the service well-led?

Inadequate

The service was not always well- led.

The provider did not have effective systems in place to regularly assess and monitor the quality of the service the home provided. The provider had not met breaches in regulation from the previous inspection and new ones had been identified.

The provider actively sought, encouraged and supported people's involvement in the improvement of the home but did not use this to improve the quality of care.

Staff did not always feel supported and valued.

People said that staff and management were always there to speak with when they needed to.

Wykeham 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. On this inspection we were following up on the warning notices issued in relation to the lack of governance and the staffing levels and other breaches from the previous inspection in August 2016.

This was an unannounced inspection which took place on 6 April 2017. The inspection team consisted of four inspectors, an expert by experience in care for older people (an expert by experience is a person who has personal experience of using or caring for someone who uses this type of service) and a nurse specialist.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. We reviewed the Provider Information Return (PIR). 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. In addition we reviewed notifications sent to us about significant events at the service. A notification is information about important events which the provider is required to tell us about by law.

During the visit we spoke with the registered manager (and other senior members of the management team) 12 people, eight relatives, 14 members of staff and a health care professional. We looked at a sample of eight care records of people, medicine administration records and supervision records for staff. We looked at records that related to the management of the service which included minutes of staff meetings and audits of the service.

The last inspection of this service was carried out on 26 and 30 August 2016 where breaches of regulations were identified in safe care and treatment, person centred care, staffing, consent, governance, dignity and respect and complaints.

Requires Improvement

Is the service safe?

Our findings

During our inspection in August 2016 we had identified a breach of regulation in safe care and treatment. Call bells were not always within reach of people, the environment did not promote safe care, medicines were not always managed safely and incidents and accidents were not always responded to appropriately. During this inspection we found some areas had been addressed but people were still at risk of unsafe care.

People were not always protected from the risks of unsafe care. One person had been left in a lounge without their call bell. They were heard calling out to staff who were busy providing care to people elsewhere. The person's care plan stated that they needed to have their call bell with them at all times. We alerted a member of staff to this person's need who came immediately. We informed them that the person did not have their call bell pendant. However the member of staff responded by asking if the person wanted to go back to their room to use their call bell, rather than acknowledging that this person should have had their call bell pendant with them.

There were other risks to people that had not been assessed or action taken to reduce the risks. One person had behaviours that placed other people at risk. Their care plan stated, 'Staff to closely observe (the persons) whereabouts'. However this person was left in their unit for an hour during our inspection not being observed by staff which potentially put other people and staff at risk. Some people at the service had bed rails and although we did not see anyone having problems with them on the day we found a lack of bed rail risk assessments in place for people. Poorly fitting bed rails can cause injury where a person can become trapped in gaps between the bed rails or between the bed rail and the bed, headboard, or mattress. Another person had been assessed as at high risk of pressure sores however we found the person had not been provided with a pressure mattress. We spoke with staff about this who took immediate action.

We were informed by a relative they had observed one person not eating their meals and not being assisted by staff to eat. We requested information from the registered manager of the person's weights and their nutritional care plan. The information we reviewed showed that the person had been losing weight since January 2017. The 'Plan of Care' in April 2017 stated that the person was 'at high risk of malnutrition' yet no food and fluid charts had been put in place and the person was not being weighed weekly. The registered manager told us that this should have been in place and told us that they would address this straight away.

As safe care and treatment was not always provided this was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were aspects of risk management that were being managed appropriately. Moving and handling risk assessments were reviewed regularly and changes implemented where necessary. One assessment described the number of staff needed and what equipment was needed for each movement and we saw that this was being followed. Falls risk assessments were taking place and guidance was in place for staff to reduce the risk of falls. For example, supporting the person when they walked and ensuring the person had the appropriate walking aids with them. Other assessments included the risk of choking and those at risk of malnutrition. One person was at risk of developing pressure sores and required repositioned in bed every

two hours and we saw that this was being done.

During our inspection in August 2016 we had identified a breach of regulation in staffing. This included concerns with the lack of staff to support people. We found on this inspection that there had been improvements with the numbers of staff available.

We asked people and relatives whether they felt there were enough staff on duty. One person told us, "(Staff levels) seems to be getting a bit better" whilst another said, "They could do with more staff."

We did not observe people waiting for care when they needed it. When we arrived staff were busy supporting people with their personal care and when people used their call bells these were responded to quickly by staff. All of the staff we spoke with told us that there were enough staff. We reviewed the dependency tool (used to assess staffing levels) and found that based on the current needs of people and there were sufficient staff to provide care. The registered manager told us that when they admitted new people to the service staff levels would be reviewed. Staff absence was filled by bank staff and agency staff. The provider was also recruiting new staff to reduce the need for agency staff.

People were protected from being cared for by unsuitable staff because robust recruitment was in place. We saw that there was an up-to-date record of nurse's professional registration. All staff had undertaken enhanced criminal records checks before commencing work and references had been appropriately sought from previous employers. Application forms had been fully completed; with any gaps in employment explained. Notes from interviews with applicants was retained on file and showed that the service had set out to employ the most suitable staff for the roles. The provider had screened information about applicants' physical and mental health histories to ensure that they were fit for the positions applied for.

Since the last inspection there had been improvements in the environment. Areas were free from clutter, people now had individual slings (to reduce the risk of cross contamination), the sluice rooms were kept locked so that people could not access them and there were personal evacuation plans for people that were individualised.

At the previous inspection there were aspects of the management of medicines that were not safe, this had now improved. We examined the Medicines Administration Records (MAR) and observed the dispensing of medication. We noted all staff dispensing medicines underwent a process of regularly checking their competency to do so. The medicines trolley was not left unattended by staff.

There were no gaps in the MAR charts. Staff were knowledgeable about the medicines they were giving. Medicines were labelled with directions for use and contained the date of receipt, the expiry date and the date of opening. Creams, dressings and lotions were labelled with the name of the person who used them. Other medications were safely stored in lockable cabinets. Medicines requiring refrigeration were stored in a fridge, which were not used for any other purpose. The temperature of the fridge and the room where it was stored was monitored daily to ensure the safety of medicines. People said they were happy with the way the medicines were given to them and knew what medicines there were receiving and why.

People told us that they felt safe from harm. When asked why they felt safe one person said, "There are always other people (staff) around and in a way we are all like a family." Another person said, "No-one can get in from outside." Relatives felt that their family members were safe. One told us, "Its far safer here than at home." People told us that if they felt unsafe they would speak to the staff on duty.

Staff had knowledge of safeguarding adults procedures, the types of abuse that could occur and what to do if they suspected any type of abuse. One member of staff said, "If I noticed abuse, I would observe closely and report to the nurse in charge. I will follow it up if the nurse in charge doesn't do anything. I would write a report." Another told us, "I have had safeguarding training. I would report abuse to the nurse or to the manager. I would speak to the resident first." Whilst another said, "If someone had bruises I would do a body map and report it straight away. If someone was very withdrawn or scared of anyone it would raise questions for me and I would tell the nurse. You have to look out for little things that are out of the ordinary for people." Staff understood the internal reporting procedures and said they would report to the Local Authority and CQC if nothing was done. Staff said that they knew about the whistleblowing policy and would have no hesitation in reporting concerns. There was a safeguarding adults policy and staff had received training in safeguarding people.

Requires Improvement

Is the service effective?

Our findings

At our inspection in August 2016 we had identified a breach in the lack of clinical skills of the nursing team. We found on this inspection that there had been improvements with the clinical skills of the nurses however non-clinical staff at the service did not always have the skills and knowledge required to support people.

People and relatives we spoke with raised concerns about the consistency of the care they received from staff that were not familiar with their needs. People felt that the permanent staff were competent, but that agency staff were not informed about their needs and had to ask them what they needed doing. One relative said, "I'm still concerned about leaving (their family member) here as they move staff around too much." They said that their family member did not like seeing different staff faces that they did not recognise. Another relative said, "The manager does a rotation with staff and from a relatives point of view it's terrible." A third relative told us, "My (family member) tells me that she doesn't recognise who the staff are."

New staff were not always supervised to help ensure they reached acceptable levels of competence to carry out their role. There were staff on their induction at the service on the day of the inspection. The registered manager told us that their role was to, "Shadow" an experienced member of staff to observe the care being delivered. However this was not happening on the day. On two of the units the inductees were left alone with people. There was no shadowing taking place and the inductees were repeatedly asked to sit with people in the lounge whilst staff assisted people in their rooms. One of the inductees was asked by staff to support a person with their lunch without giving any guidance as to how this should be done. This caused the person being supported anxiety and as a result they displayed challenging behaviours towards the new staff member. When we checked the person's care plan it stated that they did not require support to eat and that meals should be given to the person in a place where they felt comfortable. In a separate dining room we saw the new member of staff support people to eat whilst standing up and assisting two different people at the same time. Again, they had not been given appropriate guidance by experienced staff prior to helping out at lunch time.

One person displayed behaviours which were inappropriate towards staff (particularly female staff). A staff member told us that all new staff were informed of this persons behaviours; however we found this not to be the case. The inductee had not been made aware and we saw and heard this person being inappropriate towards them. Neither of the two new members of staff were able to communicate with people as they were unable to speak English. We asked another new member of staff if they had been introduced to people, they said, "No. I don't know their names." However this member of staff had been providing support to people on the day.

There was not a systematic approach to ensure staff had the skills required in order to meet the needs of people. The registered manager had moved staff around the units to help them understand the care needed for people. However this had been counterproductive as the staff did not always have the information needed to provide the most appropriate care. We observed two staff were asked to move a person from their bed as their mattress was being replaced. Neither member of staff knew the person's needs and were unsure if the person could still stand as they had been in bed for so long. They were also worried about the

person becoming dizzy. We advised them to speak to the nurse and have them present during transfer and this was done. Staff were concerned about having to work in units where they were unfamiliar with the needs of people. One told us, "It's not good, especially for those with dementia. They can't tell you if they want something or if they're in pain but when you get to know them you can tell if there's something wrong or if they're ill. They need continuity too. People don't know us either so they don't feel safe." Another told us, "I've worked a shift on every unit this week. I can't be expected to know everyone. Some people are more challenging because they don't know you. They will be fine with the staff they know but when they don't know us they're frightened and some residents fight with us because of that." The registered manager told us that this practice of moving staff around had ceased however we found it was happening on the day of the inspection.

The lack of appropriate supervision of new staff and ensuring staff had appropriate skills and knowledge to care for people was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received appropriate support that promoted their professional development. Since the last inspection in August 2016 the one to one supervisions for clinical staff had improved significantly. Clinical staff had the opportunity to review their skills with a clinical manager. At the time of the inspection a new clinical lead was in post who would continue with this support. Other staff also met with their line manager to discuss all aspects of their performance. A staff member told us, "I have supervision once a month with the nurse in charge, deputy or manager. It includes how I'm getting on, any issues, any training we want to attend, relatives complaints, any abuse we have seen." Another told us, "The manager supervises me on a monthly basis. We cover my personal life, how I'm getting on, anything I want to ask about my position and what I'm doing for the next month."

Other staff were provided training and support to meet people's needs. All staff completed a full training programme and we did observe some good practice by staff on the day. We found that appropriate care was provided in relation to wound care, catheter care and other health care needs. Clinical staff were able to describe best practice in dealing with medical emergencies and were knowledgeable about the needs of people. Where people were being moved this was done appropriately. Staff were up to date with the mandatory training and were complimentary about the training they received. One member of staff said, "My induction was nearly a month. It included manual handling, health and safety, fire safety, how to attend to personal care." Another told us, "I had refresher training three weeks ago. Health and safety, manual handling, everything." A third told us, "I have had refresher training. All my training is up to date." A fourth said, "We've done moving and handling, safeguarding, health and safety, nutrition and dementia training. Its good training and useful for what we do" and another said, "The training is good and relevant."

On our inspection in August 2016 we found that staff did not always follow the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS). At this inspection this had improved.

People's rights were protected because staff acted in accordance with the MCA. The MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. Mental capacity assessments were undertaken to ensure people's rights were protected. We saw that people's mental capacity had been assessed to determine if they needed support to make decisions about their care and treatment. We noted consent had been formally sought in a variety of areas including care and treatment. Staff had an understanding of the MCA and its principles. One told us, "It's about people being able to make their own decisions, giving people choice, not speaking for them. If someone is unable to communicate we speak to their family about what they were like and then meet their needs." Another said, "It doesn't mean people

can't make decisions, people can make decisions." A third said, "You should always assume people have capacity. We always talk to people and ask them what they want; give people time to weigh things up."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Applications for DoLS authorisations had been made where restrictions were involved in people's care to keep them safe for example in relation to people going out without being supported by staff, bed rails and the locked units.

At our previous inspection we made recommendations in relation to the environment to suit the needs of people living with dementia. There were still some improvements needed. Although the units had been decorated and furnished with sensory items, murals and objects of interest, these were all placed in the corridors which most people could not access independently. We did not see staff help to escort people to walk along the corridors. There were no sensory items in the lounge areas. There were a few colouring books and a magazine on a table in one unit, but these were all out of reach of people. The registered manager told us that there were plans to update these areas however more could have been done since the last inspection to provide sensory stimulation for people living with dementia.

People were complimentary about the food. Comments included, "It's perfect and there is a good choice", "It is divine", "It is delicious and there is always enough", "There is a good variety", "The chef must never leave!" and, "The chef will do anything we want." One person had a soft diet and said they enjoyed what they were offered.

We observed lunch being served in the dining rooms in each unit. Lunch menus were on the table for people and for those living with dementia these were in pictorial format. One person in one of the units stated that they did not want the starter on offer. The member of staff and the chef came to see them and made an alternative which the person was happy with. In another unit music was playing in the background. People were given a choice of juices and wines and were shown and were invited to choose. One staff member who was serving was explaining to people what they were giving them when putting the plate down. Comments from people during the meal included, "The food is always good. If there's something I don't like I tell them and they'll get me something else." People eating in their rooms received their meals at the same time as people in the dining room. The food looked and smelt appetising.

The chef showed us the list they had in which people's requirements were recorded. They said that those on a pureed diet had the same two choices of meal as other people. People had snacks available at any time during night as the fridge was stocked and available to staff. For those people that needed it equipment was provided to help them eat and drink independently. For example, soup was put into cups for people who found this easier. Nutritional assessments were carried out as part of the initial assessments when people moved into the service. These showed if people had specialist dietary needs. People's weights were recorded and where needed advice was sought from the relevant health care professional.

People told us that they had the opportunity to see a GP regularly, and that optician or chiropodist visits were arranged when needed. People's care records showed relevant health and social care professionals were involved with people's care. Records showed involvement of the GP, community nurse, Tissue Viability Nurse, dietician, Speech and Language Therapist and the local hospice. Staff followed the guidance provided by the health care professionals. One health care professional told us that staff always followed the guidance that they gave. They told us that they had seen an improvement in the nurse's competencies.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in August 2016 we had identified a breach in dignity and respect. People were not always treated in a way that was respectful to their needs. We found on this inspection that there were still occasions were people were not treated respectfully and with dignity.

People did not have the opportunity to have showers or baths when they wanted them. One person told us they wanted a shower every day and that this was not happening. We checked the person's care plan and it stated, 'Wants daily bath and shower'. According to the person's bath/shower record they were having a shower once a week. One member of staff told us, "There is no time to regularly bath or shower people." They said that instead they gave people a full wash in their bed. Another member of staff said, "We cannot offer clients a bath or shower regularly (as they were too busy)." We saw one person being supported to eat by a staff member who stood over them instead of sitting beside them. The member of staff walked away after five minutes and the person was left eating with their hands. There was an instance where the care being provided did not look dignified. People were having their hair done at the end of the corridor next to the hairdressing room. One person was having their rollers put in and another had a 'blow-up' dryer on their head. A third person sat in a wheelchair behind as though they were in a queue. At lunch time we saw one person being brought into the dining room with their rollers in. Staff told us that there was no reason the hair dressing salon could not have been used.

There were times during the inspection where staff were not attentive to people's needs. One person was given a meal; the person said to the member of staff, "I don't like this." The member of staff replied, "Oh it's my favourite" without acknowledging the person's statement. No alternative meal was offered to them. On another occasion a member of staff placed a clothing protector on a person without asking them or saying what they were doing. The same member of staff was seen trying to put soup into a person's mouth that was sleeping. A senior member of staff told them to leave the person however the member of staff continued. In one of the units two people were asleep for over an hour and there was no interaction from staff apart from to offer a cup of tea. One person told us, "Staff are very good, but it's like being in a hospital where they don't really have time for you." A second person said that their care could often feel rushed.

We found that one person had been without their personal specialised chair for three days. They had been sitting in the lounge on a normal lounge chair and not their recliner chair that they felt more comfortable in. The person told us that they wanted to sit in their own chair. We raised this with staff who said they had not realised that the person's chair had been placed into another person's room (by mistake) three days prior to the inspection. This person's care plan stated that it was important for the person to be sat in the chair that they had purchased. No staff had questioned prior to this where the person's chair was and had left the person in a chair they felt uncomfortable in. We asked staff to find their chair which they did.

The lack of dignity and respect shown towards people was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were aspects of the dignity and privacy that were maintained with people. People did tell us that staff

treated them with respect. We observed that staff knocked on doors and announced themselves before entering people's rooms. One member of staff said, "Doors and curtains need to be closed and have towels to cover them with (when providing personal care). Most importantly talk to people so they know what's happening." Another member of staff said that it was important to them that people received good care and they treated people with respect.

People told us that staff were caring. Comments included, "I feel looked after", "She (staff) is really nice", "They're (staff) a great crowd" and, "They are always gentle with me." Relatives also felt that staff were kind and caring. One told us, "(Member of staff) is absolutely lovely; nothing is too much trouble for him." Another said, "There are good carers. Very bright." Another relative said, "It's the best nursing home in the world. The care is second to none." We noted a letter written by a relative in the feedback book for staff stating, 'Thank you for making our mum and dads anniversary tea party so lovely for us. We were overwhelmed by your kindness and care.'

There were times where staff showed concern for people's wellbeing in a kind and meaningful way. The atmosphere in one of the units was pleasant over lunch. People were chatting easily with each other and joking. One staff member joined in with this and encouraged conversation between people. On another occasion a person looked uncomfortable in their wheel chair and this was seen immediately by a member of staff who ensured they were made more comfortable. When people went in the garden for tea staff ensured they had blankets put on knees before doing so. There were occasions where staff took time to chat with people about each other's children and you could see that people were really engaged with this. We also observed staff supporting people with the stand-aid hoist. They explained what was happening and chatted with people to make them feel at ease. People were smiling throughout.

In the afternoon one person was sat in the reception area. A member of staff was very attentive towards them. They made them a cup of tea and offered them a cake. They chatted about the person's family and friends and sat and looked at photographs together. Each time a staff member passed this person staff acknowledged them and checked that they were okay.

We raised at the previous inspection that there was not detail around people's personal backgrounds that would assist staff to make the connections with people. We found that this was still the case. There was nothing of a personal nature in people's care plans including people's past occupations and the hobbies they had. The registered manager told us that 'Getting to know me' booklets were going to be completed for people.

There was however evidence in people's care plans that people and relatives (where appropriate) were involved in the planning of their care. All of the people and relatives that we spoke with confirmed this with us. There was information around how people communicated, their spiritual needs, their likes and dislikes and whether they had a preference to a male or female carer.

Relatives and friends were encouraged to visit and maintain relationships with people. One person told us that their family sometimes joined them for Sunday lunch. They said that once when their son had travelled a long way and arrived early evening the chef had, "Made up a picnic for us to have in my room." They told us, "Visitors can come at any time and they are made very welcome." We saw staff providing re-assurance to someone about when their family member would be visiting them again.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in August 2016 we identified a breach of regulation in care planning. There was insufficient guidance in people's care plans for staff to provide the most appropriate care. We found on this inspection that this had improved.

People and relatives felt that the staff responded to their care needs well. One relative told us, "My mother fell in the night. I have no criticisms of what happened then, or indeed prior to that incident. My mother was seen by the doctor and an x-ray ordered. They kept her in bed and managed her pain. We were kept informed throughout." Another relative said, "My mother came here with sore heels. They are now better and no dressings needed. We have been happy with mothers care here."

People or their relatives were involved in developing their care and support plans. Care plans were personalised and detailed daily routines specific to each person. Pre-admission assessments provided information about people's needs and support. This was to ensure that the service was able to meet the needs of people before they moved in. There were detailed care records which outlined individual's care and support. Care plans included people's communication needs, continence, mobility, nutrition and hydration, sleeping and mental health and cognition. There was guidance to inform staff of how they needed to support people. For example, where people needed their glasses on and hearing aids in this was done. Where it was suggested that staff encourage people to walk with their frames we saw this was happening. With catheter care the care plan detailed the size of the catheter used and the date it was last changed. Pressure mattress settings were recorded dependant on the weight of the person.

Staff told us that they completed a handover session after each shift which outlined changes to people's needs. Information shared at handover related to a change in people's medicine, healthcare appointments and messages to staff. One member of staff said, "I start work at 7.00am, we have handover and then are allocated our work. We have a walk round and check all the people." Daily records were also completed to record the care provided to each person.

We asked people if there was enough to occupy them and what activities were on offer. No was able to tell us what activities were available on the day of the inspection. Comments about the activities included, "It can be hit and miss but they try their best. Trips out on a Wednesday stopped because there was something wrong with the bus" and, "They don't have many activities at all." One person told us that they could not take part in any activities because they had poor eyesight and hearing. They said they would like to listen to the radio more often but had to ask for it rather than this being offered. Another person told us, "I would very much like to go swimming as it is something I always used to do."

We asked relatives whether there were enough activities for their family members. One relative told us, "Residents are bored silly. There is very little going on. They are just sat in front of the box (television) and outings just don't happen." Another relative said, "They just sit people in front of the television. Activities are a joke. There is nothing regular going on. There is a timetable of activities but these are not put into practice." A third told us, "It would be nice if there were activities tailored to people in bed. Other people are

just sat in front of the telly."

There was very little activity taking place during the morning on the any of the units. People were in the lounge either placed in front of the television or listening to music. According to the schedule ball games were taking place but instead the activity staff went around to each unit to hand out pieces of tropical fruits. One member of staff told us, "I think there could be more things for people. There is so much they want to do. They ask to go out for lunch and drinks. There is a lot more I would like to do." Another member of staff told us, "There are no events organised this year yet. The events last year included dog Olympics, animal farm, summer fete, family barbecue, Christmas party." They told us that there was a monthly plan of activities but that this often changed.

On the day of the inspection music and movement had been planned for the afternoon but this was changed to people having their nails done. We saw this activity and saw people were all sat together with a drink whilst having their nails done. There was a nice atmosphere and people were chatting together. However this was not an option for all of the people at the service. Both activity workers were present at the activity however one of the activity coordinators could have been providing activities in another room or spending time with people in their room. There was an activity board which showed that 'trips' were offered each week to local garden centres, churches etc. However these were not taking place due to there not being a driver to transport people. One member of staff said that improvements were needed around stimulation and external activities. They told us there needed to be more going on for people. Another member of staff said, "My biggest concern is the lack of stimulation. I think the residents get very bored, and fed up. I do what I can, but there isn't the time to do more than physical care."

As people were not supported to follow their interests and take part in social activities this was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in August 2016 we identified a breach in how complaints were responded to. We found during this inspection there had been improvements in this however we have made a recommendation to the way complaints are recorded.

We asked people and relatives if they knew how to complain and who they would go to. None of the people we spoke with were aware of the complaints process but did say that they would ask their relatives to deal with their complaints. One person said they would speak to the, "Chief nurse" whilst a relative said they would speak to a member of staff. One relative said that they had made complaints in the past and it had been dealt with to their satisfaction. However this complaint had not been recorded. One person told us (and their care notes confirmed this) that they had 'Complained she was all wet and no carers had attended to her'. This complaint had not been reported and there was no record of how this had been resolved. The registered manager told us that staff should have reported this in the 'stand up meeting' so they could have investigated. We reviewed the complaints file. There was no central log to summarise the complaints with an action plan. Four complaints had been recorded since the last inspection. There was no evidence in three of the complaints to show how the complaint had been resolved. There was however evidence that the complaints had been investigated.

As complaints were not always investigated with the necessary action taken this is a continued breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our inspection in August 2016 we had identified a breach in relation to person centred care, dignity and respect, consent, safe care and treatment, the competency skills of staff, acting on complaints and lack of good governance. We issued warning notices in relation to the lack of competencies of staff and governance. The provider sent us an action plan in October 2016 that stated that they would meet these regulations by the 30 November 2016. However, we found at this inspection a systematic failure to identify and put right the shortcomings in the service as we found the warning notices had not been fully met and we identified new and continued breaches of regulations.

Records at the service were not always kept up to date and did not always reflect the most up to date care needs. This was also identified at our inspection in August 2016. One person's records stated that they were at risk of dehydration and that their fluid intake needed to be recorded. There were no fluid charts in place for this person. A member of staff told us that this was no longer needed however the guidance had not been changed. One person was on a soft diet however their care plan did not reflect this and stated that they were on a normal diet. During the inspection this care plan was updated. There was very little information as to why people were living at Wykeham in relation to their medical conditions or health needs. For example, in one person's care plan there was contradiction around what their medical diagnosis was. When we raised this with the registered manager they were unable to locate the exact details of the person's diagnosis. In another person's care plan it stated that they had been hallucinating and that records needed to be made of their behaviours. However a member of staff told us that this was no longer needed but the care plan had not been updated to reflect this. In other examples repositioning charts for people were not always being completed and there were also gaps where the application of creams needed to be recorded. One person no longer needed to be weighed weekly (according to staff) yet their care plan stated that this still needed to be done. The lack of accurate recording meant that there was a risk that staff may not provide the most appropriate care.

There were aspects to the quality assurance that were not effective and had not identified the gaps that we had identified on the day. Relatives and relatives attended meetings but these meetings were not always used to improve the quality of the service. In the relatives meeting minutes in October 2016 the registered manager stated 'Rotating staff does not work. It stresses residents and staff don't know all of the residents.' The relatives agreed with this. However a decision was made to rotate the staff onto different units. In the minutes of a residents meeting in January 2017 one of the actions was that staff were to be reminded to offer people sandwiches at night. In the February 2017 meeting minutes we found that this was still not happening and people were stating that they were only being offered biscuits.

In January 2017and March 2017 a quality assurance visit was undertaken by the provider's regional team. The audit did not identify the lack of bed rail risk assessments, the ineffectiveness of rotating staff to different units, the lack of sensory items for people living with dementia, the lack of baths and showers people were having and the lack of activities. Where aspects of the audits had identified gaps these still required improvement. For example, in relation to food and fluids charts and care plans not being updated with the most up to date care needs. These were areas that we identified on the day that had still not shown

sufficient improvement.

We asked people and relatives if they knew who the manager was. There were mixed responses to this. Out of the 11 people we spoke with, eight were unable to tell us who the manager was. We asked whether they felt the service was managed well. One person said, "It is not organised properly here." One relative told us, "I feel the manager is overwhelmed at times. I feel it's one step forward and two steps back." Whilst another said, "The manager responds when I raise things but improvements don't continue. Nobody quality assures that the improvements continue" and a third said, "(The manager) has an open ear but things aren't always followed up," whilst a fourth told us, "(The manager) is a lovely person but nothing materialises."

There was a mixed response from staff about the support they received. One member of staff said, "There's a lot of pressure on carers and they need more support and to be listened to. We never speak, none of the carers do, there's no point. The managers have made up their minds about what is happening and we have to go along with it." Another member of staff said, "It's got worse since you (CQC) were last here and the report was bad. There are managers here all the time but they don't speak to carers. They don't even say hello to us." Whilst another member of staff said, "Management listen." They told us they felt there was a good culture within the staff team and they worked as a whole, rather than four separate units. A fourth said, "The management is supportive. I see a lot of the manager. The management is working so well. There has been lots of improvement."

Staff told us that they did not always feel valued or listened to. One member of staff said, "We've told them moving staff around isn't working and people need continuity but they don't listen. They just put extra notes in the handover book about what help people need but it's not the same as having regular staff who they know." Another member of staff said, "They don't value staff at all. We are managing okay at the moment. It feels they are very much running a business first and a care home second." We reviewed the staff meeting minutes from January 2017 where staff were asked for their views on the movement of staff to different parts of the service. For the most part staff were not comfortable with this. Comments from staff included, 'I won't know what l am doing there so how can l support the residents properly', 'I like my residents and l know their little ways. They are very particular and l know they won't like it if someone new comes across who doesn't (know them)' and 'It has taken me a long time to build these relationships and l don't want them affected if things go wrong'. Despite staff views on this subject these changes had been made which affected the quality of care people received.

The lack of effective systems and processes and lack of appropriately maintained records was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider has written to us since the inspection. They have confirmed that they have taken immediate actions to address how the service is being managed. We have served requirement notices and at the next inspection within six months we will ensure that the actions they state they have addressed in their letter have been undertaken and that the changes have been imbedded.

We saw various other audits that were being used to improve the quality of care. As a result of these audits there were action plans detailing the improvements being made. This included clinical and mandatory training, the cleanliness of the service, medicine audits and the meal experience for people. We identified improvements in these areas.

In addition to this people and relatives were given an opportunity to complete surveys to provide feedback of the care being provided at Wykeham. On the whole people and relatives were positive about their experiences. Comments included, 'When visiting my mum the staff are always friendly and welcoming and

my mum seems very well cared for', 'The care is first class. Nurses and staff are lovely' and, Completely satisfied by care in this nursing home'. There were also aspects to the residents meetings where improvements were made as a result of the feedback. This included maintenance improvements and the quality of the meals being prepared.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had informed the CQC of significant events.