HC-One Oval Limited

Wombwell Hall Care Home

Inspection report

Wombwell Gardens
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Gravesend
Kent
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Tel: 01474569699

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21 July 2020

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26 August 2020

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Wombwell Hall Care Home is a residential care home providing personal and nursing care to up to 120 older people. People's needs included those living with dementia, recovering from a stroke and requiring nursing in bed. There were 97 people living at the service at the time of inspection. The service was divided into four separate units, each accommodating up to 30 people.

People's experience of using this service
People and their relatives told us that permanent staff were kind and caring and knew people well. One relative told us, "Staff are very kind and helpful although they do have to work very hard".

The overall deployment of staff was not effective as there was a lack of oversight in one unit. This was because there was no manager or permanent nursing staff to lead the staff team.

Quality assurance processes were not always effective in identifying and addressing shortfalls in the service .

Potential risks to people were not always acted on to ensure people's safety .

Records of people's care and treatment were not always accurate.

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

Rating at last inspection
The last rating for this service was Requires Improvement (published 21 May 2019).

Why we inspected
CQC have introduced targeted inspections to follow up on Warning Notices or to check 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 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 the management of the service, staffing levels and responding to risks. A decision was made for us to inspect and examine those risks.

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 to keep people safe and to hold providers to account where it is necessary for us to do so.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Wombwell Hall Care Home

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection due to specific concerns we had about the management of the service, staffing levels and responding to potential risks. We focused our inspection on one of the four units at the service.

Inspection team
The inspection was carried out by three inspectors.

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

The service had a manager registered with Care Quality Commission. The provider had appointed a person to manage the service in the absence of the registered manager. The registered manager and provider were both legally responsible for how the service was run and for the quality and safety of the care provided.

Notice of inspection:
We gave the service 24 hours' notice of the inspection. This was to establish the safest and most appropriate way of carrying out our inspection visit during the COVID-19 pandemic.

What we did before the inspection here
We sought feedback from the local authority. We completed a telephone assessment with the provider to understand how they were managing during the COVID-19 pandemic. We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

We spoke with two people who lived in the service and observed a one to one activity session in the lounge. We spoke with ten members of staff including the interim home manager, an area director, the clinical lead, a nurse, a nurse assistant and five care workers.

We reviewed a range of records. This included five people's care records, medicines audits and COVID-19 safety protocols.

After the inspection:
At the beginning of our inspection visit we asked the provider to send us a range of records relating to the management and quality of the service, and the deployment of staff. We received this information in the week following our inspection. We telephoned four relatives to gain their feedback about the service.

Inspected but not rated

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 requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about. We will assess all of the key questions at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management

At our last two inspections of the service the provider had failed to robustly assess and manage 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.

- Information about potential risks to people and how to minimise them was not always comprehensive nor accurate. Therefore, staff did not have all the guidance they needed to support people in a safe and consistent way.
- There was inconsistent directions for staff about how to support people who had been assessed at high risk of developing pressure ulcers. Staff were guided to reposition some of these people every two to four hours, but not other people at high risk. Records did not show people who needed assistance to move in bed were regularly supported to do so. This increased the risk of people avoidably acquiring sore skin as regular repositioning often contributes to promoting healthy skin.
- One person had been assessed as requiring bedrails to keep them safe and this was recorded in their care plan and professional communication record. However, we saw this person had no bedrails but a crash mat on their bedroom floor. Staff told us the bedrails had been removed as the person kept trying to climb over them and had fallen. There was no risk assessment record to evidence how and why this decision had been made or that it was in their best interests. This increased the risk of the person not receiving the most effective support to reduce the chance of them falling.
- Some people had been assessed as requiring a fluid chart to make sure they have sufficient amounts of hydration. There was inconsistent fluid records for one person who had a history of chronic renal problems and frequent urinary track infections. It is especially important that people with these health conditions have enough to drink but records did not evidence this.
- Some people could become anxious and communicate these feelings verbally and physically. A staff member described how they distracted one person when they become anxious as they knew them well. A record was made of what happened before and after this person became agitated. However, there was no guidance for staff about how to provide the appropriate, positive support for this person, in a consistent way. A consistent approach helps to lower people's anxieties.
- Up to date records about risks are particularly important at this service in order to ensure safe and appropriate care, as a number of agency nurses and care staff are employed.
- Part of the provider's protocol to keep people safe during the COVID-19 pandemic included regular testing of people for COVID-19 and daily temperature checks to alert staff to any symptoms. However, daily

temperature checks were not being carried out for everyone.

Failure to robustly assess and manage the risks relating to the health safety and welfare of people is a continuing breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last two inspections of the service the provider had failed to ensure safe staffing levels. This was a breach of regulation 18 (Staffing) 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 18.

● There were mixed responses from people, their relatives and staff about staffing levels. Some feedback there were enough staff and people were given assistance in a timely manner. However, others gave examples which indicated there were not sufficient staff available. This included one person soiling themselves whilst waiting for their call bell to be answered and another person's clothes still being in their original bags three days after they moved to the service.
● People were not always supported by consistent staff who knew them well. This was because there were not enough permanent nurses or care staff available to meet people's assessed needs. Staff told us there was little consistency in the agency staff used to cover gaps in the staff rota.
● Most people were cared for in bed and had complex needs. There was no one appointed to manage the unit and this vacancy had not been filled since our last inspection. There were also no permanent nurses. The other three units had a consistent unit manager and some permanent nursing staff. Therefore, the deployment of staff and skills mix was not effective in the overall staffing of the service. This shortfall was not directly due to the effects of COVID 19.
● We raised our concerns with the area director who told us steps were being taken to improve the staffing at the service. The deputy manager was being assigned to the unit two days a week. In addition, agency nurses were being approached to work all their shifts in the unit. This was to help them develop their knowledge of the care being provided, to promote consistent care delivery and to build good team-work. A nurse confirmed they had agreed to this way of working.

The failure to ensure sufficient staff are deployed to meet people's needs is a continued breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Inspected but not rated

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 requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about. We will assess all of the key questions at the next comprehensive inspection of the service.

Continuous learning and improving care
At our last two inspections of the service the provider had failed to keep accurate records, and there were not effective systems to assess, improve and monitor the quality of care. 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.

- Feedback from relatives was that staff were kind and caring, but the service was not always well-led. One relative told us, "It's nothing too dire but the place is just disorganised, no one seems to quite know what's going on. It doesn't give me confidence in the service and that's what you need really."
- The provider had not addressed shortfalls identified at this inspection concerning the deployment of staff and risk management.
- The registered manager had been absent from the service since 1 April 2020. In their absence two different turnaround managers had been appointed. Three managers in a five months period impacts the overall consistency in the running of the service.
- Quality monitoring systems and audits were not always effective in identifying shortfalls in the quality of care. When the provider had identified improvements were required, these had not always been embedded in the service.
- At a clinical meeting in May 2020 the importance of documenting pressure areas and completing weekly weight and turn charts was discussed. However, we found shortfalls in records relating to skin integrity during this inspection.
- Shortfalls in wound audits were not addressed in a timely manner. An audit at the beginning of July highlighted that for one person there were no pictures or measurement of their wound, that their care plan had not been updated nor a record made after a dressing had been applied. An audit the following week showed that the wound had still not been measured and their care plan had not been updated. The part of the form which indicated what action the nurse needed to take to rectify the shortfall was left blank. Photographs indicated that the wound was beginning to heal.
- The service's improvement plan states that hydration champions are in post to ensure people's fluid charts are completed on each shift. However, we found fluid charts had not always been completed daily.
- Records of people's care and treatment were not always easy to understand. Wound assessments and nursing notes were kept in different files so both were needed to establish the if people's treatment plans had been followed. When investigating a concern, the provider was unable to find one person's clinical records for a three-week period.

The provider had failed to ensure there were effective systems to assess, improve and monitor the quality of care. Also to ensure there were accurate records about people's care and treatment. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to robustly assess and manage the risks relating to the health safety and welfare of people. Regulation 12 (1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure there were effective systems to assess, improve and monitor the quality of care. Also to ensure there were accurate records about people's care and treatment. Regulation 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failure to ensure sufficient staff are deployed to meet people's needs is a breach of Regulation 18 (1)