Country Court Care Homes 2 Limited

Walberton Place Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Walberton Place Care Home is a residential care home providing personal care to people aged 65 and over. The service can support up to 80 people, there were 78 people living at Walberton Place Care Home at the time of inspection. The service supports people who may be living with dementia or need support with their physical health. Walberton Place Care Home is a large purpose-built building over two floors. Each floor has separate facilities such as dining areas, lounges and places to socialise. The first floor is a specialist unit for people living with dementia. The building is surrounded by gardens and has an internal, enclosed courtyard garden.

People's experience of the service and what we found:
Risks to people were not consistently assessed and managed. Risk assessments and care plans did not always contain the information staff needed to provide safe and effective care and staff did not always know how to support people's needs.

People were not always receiving their medicines safely and according to prescriber's instructions. People were not consistently safeguarded from improper treatment. Infection prevention and control procedures were not reviewed and updated, and staff were not provided with clear guidance and support. Governance and management systems were not effective in identifying these shortfalls.

Staff did not always have the skills they needed to support people's needs. Systems for monitoring care and support were not effective in driving improvements. There was poor leadership and ineffective oversight of quality and safety. There had been a failure to make and sustain improvements over time.

People and their relatives described staff as being kind and caring. There were safe systems in place for the recruitment of staff

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 10 June 2023). At this inspection enough improvement had not been made and the provider was still in breach of regulations. This service has been rated requires improvement for the last four consecutive inspections and the service is now rated inadequate.

Why we inspected

The inspection was prompted in part due to concerns received about risk management and leadership. A decision was made for us to inspect and examine those risks.
The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of hydration and nutrition. This inspection examined those risks.

You can see what action we have asked the provider to take at the end of this full report. Please see the safe and well led sections of this full report. We undertook a focused inspection to review the key questions of safe and well-led only. For those key question not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

Enforcement
We have identified breaches in relation to management of risks, safeguarding, staffing and the management and governance of the service. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow Up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.
If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Walberton Place Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection team consisted of 4 inspectors

Service and service type
Walberton Place Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Walberton Place Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

Notice of inspection
The inspection was unannounced

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our

inspection.

During the inspection
We spoke with 5 people and 4 relatives. We spent time observing staff interactions with people and 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. We spoke with 10 staff including 3 care staff, 3 senior care staff, 2 hospitality staff , 1 deputy manager, and the registered manager. We spoke with 2 visiting health care professionals. We looked at records relating to people's care and the management of the service. This included 9 care plans, 4 staff records, staff rotas, training plans and management records.

Following the inspection we received further management documents including an updated service improvement plan and we spoke with the Nominated Individual for the service. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has deteriorated to inadequate . This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management;
At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had not made enough improvements and the service remained in breach of the regulation

• The provider did not always assess risks to ensure people were safe. Staff did not always take action to mitigate any identified risks including risks associated with choking, health conditions including epilepsy, sensory loss and dementia.
• A person was receiving end of life care and had been assessed as being at high risk of choking. They needed a modified diet and had thickening powder added to drinks to support them to swallow fluids. Not all staff were aware the thickening powder was required in all drinks. Staff had been providing the powder in some, but not all drinks, this increased risks of choking or aspiration when drinking.
• We observed a staff member trying to support the person with a modified meal at lunchtime. They had attempted to support the person into an upright position, but the person was not alert and appeared to be unaware of what was happening. Despite the lack of response, the staff member continued to encourage the person to eat the food which they had put into their mouth. The person did not respond and did not swallow the food, this meant they were at increased risk of choking or aspiration. The staff member then used a tissue to remove the food from the person's mouth. This did not support the person's safety or dignity. We raised a safeguarding alert with the local authority for this person.
• Some risks to people were not effectively managed. Health conditions including epilepsy, visual sensory loss and a brain injury were identified during a pre-admission assessment for one person who had had a history of falls. There was no risk assessment to provide staff with information about the level of risk or the impact of these conditions, and no care plan to identify the support the person needed to manage these risks.
• A person who was living with dementia was expressing their feelings of distress and anxiety throughout the inspection, staff told us this was not unusual. We observed staff were not consistent in their approach. Some staff appeared to lack confidence and did not know what to do. Some staff approached the person, held their hand and reassured them, this appeared to calm them. Other staff ignored them or encouraged them to be quiet. We asked a staff member how they supported the person to reduce their anxiety and they told us, "There's nothing you can do really." There was no risk assessment or care plan to guide staff in how to support the person. The registered manager told us they had not considered it necessary to have a risk assessment and care plan in place but agreed to contact the Older People's Mental Health team for support with this.

The failure to ensure that risks were effectively managed was a continued breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely;
• People were supported to receive their medicines in a way that was not always safe.
• Some medicines were prescribed PRN or "as required." There were protocols in place to guide staff in when PRN medicine should be administered. Some PRN protocols were not being consistently followed by staff and medicine administration record (MAR) charts were not clear. This did not provide assurance that PRN medicines were being administered safely, in line with prescriber's instructions and to good effect.
• One person was prescribed PRN medicine. A PRN protocol described when the medicine should be administered and how often, including the maximum dose of medicine in a specific time period. The prescribed dose was not being administered consistently and records were not clear and accurate to confirm what dose had been given.
• Some medicines needed additional checks and a system was in place with two staff signing to verify the stock of medicine was correct. The record for one medicine was incorrect but the error had not been identified by the staff who signed to say it was correct.
• One person had been prescribed medicine for pain relief. There was no record to support administration of this medicine and it was not identified within their care plan. This meant staff who were administering medicines may not have been aware this medicine was available for this person. The registered manager said they were not aware the medicine was being kept for this person or why it had been prescribed and agreed to contact the prescriber immediately to clarify this.

The failure to ensure the proper and safe administration of medicines was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• Medicines were stored securely and staff were trained and assessed as competent before administering medicines.
• We observed staff supporting people with their medicines in the way they preferred.

Preventing and controlling infection
• People were not always protected from the risk of infection as staff were not consistently following safe infection prevention and control practices
• When we arrived at the inspection we were informed there was an outbreak of COVID 19 at the home. Staff said people who were symptomatic and had tested positive, were isolating in their bedrooms on the ground floor.
• We observed not all staff were wearing masks and some staff told us they were not sure whether they should be wearing PPE or not. The registered manager confirmed they were not aware of current government guidance and had not reviewed the risk assessment for the service but agreed to do so.
• Some relatives told us they had not been informed about the outbreak although it had started during the previous week. One relative described bringing a test kit in for their relation who had symptoms because the home did not have any kits. The person had tested positive for COVID 19 although a staff member had told them their relative had recovered, this person was later admitted to hospital.

The failure to ensure infection prevention and control risks were assessed and managed was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
• We raised these concerns with the Nominated Individual who took immediate actions to address shortfalls in managing the outbreak.
• People were able to receive visitors without restrictions in line with best practice guidance.

Systems and processes to safeguard people from the risk of abuse and avoidable harm;
• People were not always protected from abuse and improper treatment. We raised safeguarding alerts for 2 people following this inspection due to concerns about improper treatment and potential neglect.
• Some people were prescribed medicine to support heightened anxiety and feelings of distress. There were no guidelines for staff about alternative options to reduce one person's anxiety before administering the medicine. There was a lack of records to identify patterns, trends and triggers for their distress and inconsistent records to identify the reason for administering the medicine. We were not assured the medicine was always being administered appropriately. We raised a safeguarding alert with the local authority for this person.
• Some people were not receiving the care and support they needed, including for end of life care. The end of life care plan for one person was not detailed and did not include guidance for staff in how to support them, including about how often to provide mouth care during the last days of life. A visiting health care professional raised concerns about the continued lack of mouth care which was affecting the comfort of the person. We brought this to the attention of the registered manager who arranged for the person to be supported with mouth care immediately. We raised a safeguarding alert for this person.
• Safeguarding incidents had not always been reported and investigated in line with the provider's policy. For example, some incidents had not been identified as potential safeguarding and had not been reported. The local authority told us there had been an increase in the number of safeguarding concerns reported by health and social care professionals who visited the home. This did not provide assurance that all appropriate actions had been taken to ensure people's safety.
• Although staff had received training in safeguarding, staff we spoke with were not always able to describe how they would recognise signs of abuse and what action they would take.

The failure to ensure people were safeguarded from risks of abuse and improper treatment was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
• A relative told us, "Staff are kind and they look after people well, I have no concerns about safety. They do what they can to keep people safe."
• Following the inspection, the nominated individual sent us an action plan including details of improvements they had put in place to address safeguarding concerns.

Staffing and recruitment
• The provider had not ensured all staff had the skills and competence to provide care safely.
• Staff had received training the provider considered to be essential for their roles, however, they did not always have the skills required to meet people's needs. For example, staff had failed to identify, recognise and mitigate risks to people, this meant people were at increased risk of harm. A person was identified as having an allergy . Staff we spoke with were not aware of what might happen or what actions to take if the person was to have an allergic reaction.
• Some people had additional needs for which staff had not received training, including for example, substance misuse. Staff were not clear about how to support people effectively and care plans did not always provide clear guidance.
• A health care professional told us staff sometimes lacked confidence and did not have the skills or experience to support people's needs. For example, when people fell staff were not always confident in checking for injuries and supporting them to get up. They told us this had resulted in a higher then expected number of calls to the ambulance service.
• Staff did not always recognise when people needed support. For example, a relative told us they had concerns about nail care, including supporting people to keep their nails clean. They told us they had to ask staff to support their relation. One person showed us their nails which had grown very long. We asked a staff member about this but they were not aware if this was the person's choice or whether they needed support

to manage their nail care.

The failure to ensure staff had the skills, competence and experience to meet people's needs was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• Relatives we spoke with said there were usually staff around to support people. One relative told us, "They have more staff now, they come quickly if the alarm (mat) goes off."
• The provider had safe systems in place for recruiting staff. Appropriate employments checks were made about prospective staff to ensure they were suitable for the roles they had applied to. This includes references being sought and DBS checks being made. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Learning lessons when things go wrong
• The provider did not always learn lessons when things had gone wrong.
• The provider had systems in place for recording and reporting incidents, however these were not always effective. This included use of ABC charts which are an observational tool to help identify possible reasons for behaviour. Staff used ABC charts to record the events before, during and after an incident. This system was introduced to support evaluation of incidents, including when people were in distress or showing signs of heightened anxiety. This was to help staff identify possible reasons or triggers for the incident, and to enable changes to care plans that would reduce the chance of further incidents occurring.
• ABC charts were not completed consistently. Some staff were not aware of their use and could not describe how they would complete them. This meant there were missed opportunities to reflect on possible causes of incidents and to make changes or try different approaches. This remains an area of practice that needs to improve.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS)
• The provider was working in line with the Mental Capacity Act.
• People's mental capacity to make specific decisions had been assessed and recorded in their care plans. For example, a person needed medicine to be administered covertly (that is without their knowledge or consent). An appropriate mental capacity assessment had been completed with involvement of the GP and a best interest decision was recorded.
• DoLS authorisations were up to date and monitored. Applications were made to the local authority when authorisation periods had ended.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider had failed to ensure systems for governance were operating effectively to improve the quality and safety of the service. Records were not consistently accurate. At this inspection the provider had not made enough improvements and the service remained in breach of the regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Failings in the management and oversight of the service had been found at the previous 3 inspections. This meant there had been a continued failure to make, and sustain, improvements over time.
- The provider's system did not always effectively monitor the quality and safety of care provided to drive improvements and mitigate risks.
- The provider's governance systems included audits for medicine administration, risk management and care planning. These audits had not identified shortfalls we found. For example, regular checks and audits of medicines were in place but this had not identified recording errors, inaccurate recording and discrepancies with stocks of medicine found at this inspection.
- Audits of care plans and risk assessments were regularly undertaken but had failed to identify when information was omitted or records were not accurate. For example, a person was at risk of dehydration and required their fluid intake to be monitored. Records were not being kept to provide assurance they were receiving enough to drink, although a care plan audit confirmed all records were completed. Where risks to people had been identified there were not always risk assessments and care plans in place to support people's needs. Audits had not identified these omissions. We were not assured of the accuracy and effectiveness of the auditing process.
- Incident and accidents were monitored and analysed to identify patterns and trends, including for falls. However, this process was not effective in driving improvements. For example, analysis of falls for July, August and September had identified an increase in the number of unwitnessed falls each month. The action plan identified that staff needed to ensure they were monitoring people in bedrooms and communal areas. The same action was noted for each month but had not brought about any improvement in the number of falls which had doubled between July and September. This meant systems were not effective in identifying learning and driving improvements in the quality and safety of care.

There remained a lack of effective systems for oversight and governance and a failure to ensure accurate records were kept. There was a failure to ensure that plans to improve the quality and safety of the service

were achieved and sustained. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong:

• There was not always a positive and open culture at the service. The provider had not consistently created a learning culture at the service which meant people's care did not always improve.
• Staff told us they did not feel well supported and described a culture where their views were not always welcomed. Their comments included, "Our views are not considered important." "I don't speak up, there's no point." The provider's systems for monitoring feedback from staff had not identified these issues. We raised concerns about communication and the culture of the home with the nominated individual who took immediate action to investigate and address these concerns.
• People and their relatives told us the care staff were kind and caring but there were concerns about communication at the home. One relative said, "Communication can be tricky with a high turnover of managers and staff."

The failure to ensure systems for seeking and monitoring feedback were effective and supported improvements in the quality and safety of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• Following the inspection we received an action plan detailing improvements the provider had put in place and further planned improvements to support an open culture. This included ensuring staff, people and relatives had more opportunities for involvement in the service. There were also plans to support staff with further training and development.
• People and their relatives were involved in developing their care plans. One person described being involved in the assessment process. They told us, "I was consulted and they involved my social worker and the neurologist too." A relative said, "I was involved and they put (person's name) at ease straight away."
• The provider understood their responsibilities under the duty of candour.

Working in partnership with others
• The provider did not always work effectively in partnership with others.
• A visiting health care professional described concerns with communication saying, "There are massive issues with communication between people and staff and staff and professionals, across the home." They explained how they had spoken with the registered manager about failures in the provider's systems for admitting people to the service and how this had led to increased risks for some people due to the lack of available information for staff. An example included the failure to obtain information from a GP surgery for a person, this meant staff did not have all the relevant information they needed.
• Feedback from health care professionals included concerns about the failure to embed learning and the negative impact this had on outcomes for some people. For example, staff had received additional support with understanding catheter care. The manager had not ensured learning was cascaded to all staff who needed it. A health care professional told us, "It's not embedded, they are not managing catheter care well. Improvements we saw (following the training) have not been sustained."

The failure to work effectively with partners meant improvements in the quality and safety of the service had not always been actioned, embedded and sustained in practice. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• Staff described working in partnership with health and social care professionals on a regular basis.

• Care records included details and advice from health care professionals including district nurses, hospice staff and community matrons.
• Visiting health care professionals described working with staff to improve their knowledge and understanding for example they had provided training sessions for staff including in dementia care.

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 18 HSCA RA Regulations 2014 Staffing There was a failure to ensure staff had the skills, competence and experience to meet people's needs

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to ensure that risks were effectively managed, the failure to ensure the proper and safe administration of medicines, and the failure to ensure infection prevention and control risks were assessed and managed was a breach of regulation

The enforcement action we took:

positive condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was a failure to ensure people were safeguarded from risks of abuse and improper treatment .

The enforcement action we took:

positive condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of effective systems for oversight and governance and a failure to ensure accurate records. There was a failure to ensure systems for seeking and monitoring feedback were effective and supported improvements in the quality and safety of the service

The enforcement action we took:

positive condition