St. Martin's Care Limited

Washington Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 2 and 3 February 2016 and was unannounced. The service was last inspected in January 2014 when the service met the standards we inspected against at the time.

Washington Manor is a residential home which provides personal care for up to 68 people, with dementia or general care needs. There were 62 people living there at the time of our inspection.

The service did not have a registered manager but a manager had been in post since May 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social care Act 2008 and associated Regulations about how the service is run.

During this inspection we found the provider had breached a number of regulations. Suitable numbers of qualified staff were not available at all times. People's care plans did not always reflect individual needs and were sometimes incomplete. The provider's audits had not identified the concerns we had about staffing levels.

Although the service looked clean there were odours on the first floor, and some areas needed redecorating.

A significant number of people told us they did not like the range of food available, and it was not up to standard.

Whilst staff responded appropriately when people's needs changed, the provider did not always respond appropriately. There were several people with dementia who lived on the residential floor. Their needs could have been met better if they lived on the floor for people living with dementia.

Checks on equipment such as wheelchairs and hoists were not always carried out regularly. Regular premises maintenance checks were carried out.

Medicines were managed in the right way. Medicine administration records we viewed contained no gaps or inaccuracies.

Staff received regular supervisions and appraisals to assist their professional development.

People's weight was checked regularly and action taken where concerns were identified. Referrals to health care professionals such as the community nursing team, dietician or GP were made appropriately.

The service was working within the principles of the Mental Capacity Act 2005. Deprivation of Liberty Safeguards (DoLS) applications had been made appropriately and contained details of people's specific

needs.

People and their relatives told us staff were kind and caring. Staff knew people well and how best to support them if they were anxious or upset. People's dignity was maintained and their choices respected.

Staff told us the management team were supportive and approachable.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Suitable numbers of qualified staff were not available at all times. People and relatives said there weren't enough staff on duty.

Ongoing checks were not always carried out to ensure staff were suitable to care for vulnerable adults.

There was a clear system in place for the safe administration of medicines.

Checks on the maintenance of the premises were carried out regularly.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received up to date training in a number of key areas.

People told us they didn't like the menu choices available and would prefer 'plain food'.

Referrals to health care professionals were made when people's needs changed.

Staff received regular supervisions and appraisals.

Is the service caring?

Good

The service was caring.

People and relatives spoke positively about the staff.

Staff reassured and comforted people if they were anxious.

Staff knew people well, particularly those who were not always able to express their wishes clearly because of their dementia

The service advertised advocacy support for people who could not always speak for themselves.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always person-centred or complete.

Relatives were not always involved in decisions about their family members' care.

Relatives told us they were not always happy with how complaints had been dealt with.

Staff responded to changes in people's needs appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider's quality assurance system did not identify our concerns in relation to staffing levels.

Where improvements had been identified there was no clear action plan in place to identify when actions would be complete.

Staff spoke positively about the management team being approachable and supportive.

Washington Manor Care Home

Detailed findings

Background to this inspection

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

This inspection took place over two days. The first visit on 2 February 2016 was unannounced which meant the provider and staff did not know we were coming. The second visit on 3 February 2016 was announced.

Day one of the inspection was carried out by one adult social care inspector and one specialist advisor. One adult social care inspector visited on the other day.

Before our inspection we reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also contacted the local authority commissioners for the service, the local Healthwatch and the clinical commissioning group (CCG). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This inspection was brought forward due to safeguarding concerns that had been reported to us regarding the number of staff on duty.

During the visit we observed care and support and looked around the premises. We spoke with 12 people who used the service, six relatives, the manager, the deputy manager, two senior care assistants, the activities co-ordinator, six care assistants, two kitchen staff and one domestic staff. We also spoke to a GP and a community nurse who were at the service during our inspection. We looked at a range of records which included the care records for six people who used the service, medicine records for 34 people, recruitment records for six staff, and other documents related to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

The provider did not have effective systems in place to ensure there were sufficient numbers of suitably qualified staff on duty. At the time of our inspection 62 people were using the service. There were 34 rooms on the ground floor for people with general care needs, and 34 rooms on the first floor for people living with dementia. Staffing levels through the day for both floors were two senior care assistants, seven care assistants and one activities co-ordinator. There were also three domestic staff, one of whom was based in the laundry, and three kitchen staff. During the night five staff members were on duty; one senior care assistant and four care assistants. We reviewed rotas for the past month and noted staffing levels were as described by the manager and deputy manager. The service employed around 45 staff.

Call bells were not always answered promptly and at times there was no visible staff presence in areas of the service where vulnerable people sat alone or in groups. This meant people were at risk of harm. Staff prioritised people's needs but people's needs were not always dealt with promptly. Nine staff told us they had little time for one to one contact with people, which they felt was an essential aspect of their job role, especially when providing care to people living with dementia.

At one meal time there were 21 people in the dining room with one senior care assistant and one care assistant supporting them; some of these people needed support to eat. There were seven people in a small dining room who all required assistance to eat. They were supported by one care assistant. This meant there was a potential delay in people getting support with their food, which meant there was a risk of it going cold. During meal times we observed people were often brought to dining rooms some time before the meal was served which meant some people with dementia became anxious.

We asked people and their relatives about the staffing levels. One person told us, "They are very short of staff all the time." One relative told us, "I worry about toileting as there never seems to be enough staff." A second relative said, "Staff are so caring, but there's not enough of them." A third relative said, "The level of people's dependency, especially those with dementia, is not reflected in the staffing levels." A fourth relative told us, "There aren't enough staff. The staffing levels are totally inadequate for people with dementia."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the manager if they thought there were enough staff and how staffing levels were calculated. They said they felt they had enough staff on duty. Each person who used the service was given a dependency score which fell into the categories of low, medium or high, and the provider's staffing dependency formula was then used to work out staffing numbers. The manager said the staffing dependency tool was reviewed monthly to account for changes in people's needs. The manager said the provider was looking at a new dependency tool to "manage staff more effectively".

We reviewed six staff recruitment files. Thorough background checks had been carried out to ensure staff were suitable to care for vulnerable adults before employment. Three of the six staff files we viewed did not

contain up to date disclosure and barring service (DBS) checks in line with the provider's policy, which stated checks should be repeated every three years. DBS checks help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable adults. A book was used to record the details of DBS checks but this was an ineffective system as records were inaccurate.

Safeguarding incidents were usually logged and dealt with appropriately. During the inspection we became aware of a safeguarding concern we had not been notified about. We discussed this with the manager and they agreed to notify us about this formally. The provider had dealt with the staff member concerned appropriately.

27 safeguarding incidents had occurred in the last 12 months. These were referred to the local safeguarding team and further actions were logged appropriately. They were analysed by the provider and lessons learned were noted.

During our inspection we noted the service looked clean, but there were odours on the first floor. Some bedrooms were untidy with unmade beds and the curtains closed some time after people had got up and dressed. Bathrooms and shower rooms were cluttered with trollies containing towels, spare underwear and spare sheets. Some areas of the service looked worn and needed redecorating.

Accidents and incidents were recorded and dealt with appropriately. There had been an increase in falls so the manager implemented individual falls records for people, which were then analysed to identify trends, but it was not always clear what action had been taken as a result.

Each person had a personal emergency evacuation plan (PEEP), which had specific details about the physical requirements people had. This would help people to be evacuated safely in the event of a fire.

Regular maintenance checks of the premises were carried out on window restrictors, water temperatures and bed rails. Checks of equipment such as wheelchairs and hoists were not always completed regularly, or records of such checks were not always completed fully as dates were missing. Other maintenance checks such as electrical and gas safety and legionella checks were up to date.

Medicines were managed in the right way. We observed the medicines round and saw this was unhurried and was tailored to each person's individual needs. The 34 medicines administration records (MAR) we viewed contained no gaps or inaccuracies. A local pharmacy supplied medicines in blister packs monthly, and the medicines ordering system worked well. This meant people's medicines were delivered promptly so they received them on time.

Medicines were securely stored in two medicines trolleys which were kept in the basement, or in the treatment room when in use. Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Records were kept of the usage of controlled drugs so as to readily detect any loss. This meant the arrangements for controlled drugs were safe. The temperature of the fridge, used for medicine such as eye drops, and the treatment room where medicines were kept, was checked regularly and was within recommended limits.

Requires Improvement

Is the service effective?

Our findings

The provider did not have effective systems in place to ensure staff were given appropriate training. Training records showed 73% of staff had not completed training on behaviour that might challenge others, 49% had not completed Mental Capacity Act training and 58% had not completed Deprivation of Liberty Safeguards training. Also, 71% of staff had not completed pressure ulcer prevention training, 40% had not completed end of life care training, and only five staff had been trained in the safe administration of medicines. 89% of staff had not received dignity training and 33% had not completed infection prevention and control training.

A representative from the speech and language team (SALT) told us, "Whilst staff are generally kind and enthusiastic, they have very little knowledge about swallowing disorders (dysphagia). There have been two complex cases involving residents at this home, and the standard of care would have been safer if staff had a better knowledge of the recommendations and why their input impacted on the residents' health, e.g. getting chest infections, increased risk of choking episodes." They recommended staff attend training in this area so people could be supported to eat more safely.

We asked the manager about staff training and they said they were addressing it, but a significant amount of staff had not received up to date training. This meant we could be sure staff knew how to care for people in the right way. Several staff told us they would like more training.

This was a breach of Regulation 18 health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed meal times and saw that people were offered a range of options. For example, at breakfast time four different cereals, porridge, scrambled eggs, a full cooked breakfast, toast, juice, tea, coffee, and fresh fruit were available. One person said, "We can get anything we want for breakfast." At lunch time, in addition to the two hot main meals were 'light bites' of sandwiches or a jacket potato. Menus were on display outside the dining room on the first floor in picture format, but this wasn't updated on the second day of our inspection.

A significant number of people told us they did not like the new menu, which had been introduced in October 2015, and the food was not up to the standard they expected. They also told us tea and coffee was "rarely hot". One person told us, "I don't like the new menu. There's not much on there that I would eat. I like plain food and the food doesn't look appetising." Most people we spoke to said they liked 'plain food', but the menu contained chilli and curry which people said they did not like. Homemade cakes and homemade biscuits were available on the tea trolley which went round a few times a day. People told us they liked the homemade cakes but preferred shop bought biscuits. Fruit was also available on the afternoon tea trolley.

When we asked the manager and chef about the new menu they told us it was brought in after they noticed some people had lost weight. Kitchen staff we spoke with were aware of people's negative feedback on the new menu. The manager told us they were reviewing the new menu in light of people's feedback, but there was no clear plan and timescale for this.

We looked at how the provider supported staff development through supervisions. Supervisions are regular meetings between a staff member and their manager to discuss issues around the needs of people who use the service, future training needs and how their work is progressing. The provider's policy on supervisions said they should take place five times a year, and records showed this had happened. Staff also received an annual appraisal; records showed these were up to date. One staff member said, "I feel supported to do my job."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager kept a record of each person who had a DoLS authorisation in place. Applications which contained details of people's individual needs and how decisions made about DoLS were in people's best interests had been made to the relevant local authorities. Staff had a basic understanding of these issues.

People's weights were checked, recorded and audited monthly. Where people had lost 1 or 2 kg they were more closely monitored. Clear action was taken after weights audits, for example people were referred to the dietician. Staff told us they used fortified drinks and encouraged people to eat more snacks when it had been recommended by health care professionals. A community nurse who was visiting the service during our visit told us, "The nutritional analysis here is really good."

The manager said, "We've got a good relationship with the district nurses and other health care professionals." The manager had implemented a communication diary for the community nursing team to use when they visited the service. Staff told us this worked well which meant information about people's needs was passed between care staff and community nurses. A GP who was visiting the service during our visit told us, "The staff are informed and sensible, there are no needless call outs."

Good

Is the service caring?

Our findings

People and relatives spoke positively to us about the staff. One person told us, "We're well looked after here. The girls are lovely." Another person said, "I am well cared for and looked after here. I am lucky because I have no worries." One relative told us, "The staff are absolutely lovely and dedicated." Another relative said, "I really can't fault the care staff. [Family member's] dignity is always upheld. The staff always speak to people nicely."

Some people were unable to fully communicate their opinions about the care they received, but we observed positive relationships between staff and people living at the service. Throughout our visit staff spoke to people in a kind and considerate manner. Staff knew people well, particularly those who were not always able to express their wishes clearly. Staff reassured people who were anxious or upset in a kind and gentle way. Staff dealt with people whose behaviour may challenge others in a compassionate way. A senior care assistant had been a finalist at the Great British Care Awards 2015.

When providing personal care staff had a good understanding of how to ensure people's dignity. Staff knocked on people's doors before entering and waited for a response. People's independence was also encouraged, for example staff supported people to go to the local shop. Staff told us how important it was to respect people's choices and rights. We saw this in practice when staff asked people where they wanted to eat their meals, and where they wanted to sit when they were reliant on staff support for mobility. Staff explained things to people and talked to them while carrying out care tasks. Staff used appropriate touch and showed affection to meet people's emotional needs.

The service had received several written compliments from relatives. One person wrote, 'I have always found and continue to find all of your staff friendly and they all show great kindness to [family member].' Another relative wrote, 'I am always heartened by the caring approach that staff show [family member] and all of the other residents. They are great.'

Other written compliments from relatives included, 'All of the family appreciate the real kindness and genuine friendship from all of the staff'; 'I just had to express my gratitude on how well my [relative] is being cared for and supported in your wonderful home by a very caring, dedicated and professional staff'; and 'All staff are very helpful and well informed of [relative's] needs.'

A representative of the local speech and language team (SALT) told us, "Most carers are responsive to the individual's needs and have friendly, good rapport with the residents. The staff have all offered helpful knowledge of the resident and I have seen good examples of kindness, compassion, dignity and respect." A GP who visited the service during our visit told us, "The staff are very caring."

The registered manager told us no one at the service currently had an advocate supporting them. The resident guide advertised advocacy support from external agencies. An advocate is someone who represents and acts on a person's behalf, and helps them make decisions.

Requires Improvement

Is the service responsive?

Our findings

Care plans and individual risk assessments were not always completed fully and did not reflect the specific needs of the individual. For example, some care plans had no photograph of the person, and pre admission assessments, life histories and dining preferences were incomplete. Some care plans contained inconsistencies such as recording a person used the toilet independently, but elsewhere in the care plan it was recorded they were fully reliant on staff for continence support.
Comments in some care plans were not always meaningful. For example, in a section titled 'psychological, emotional and spiritual wellbeing' one person's care plan stated 'eats well, chatty and uses toilet' which gave no indication of the person's needs in these areas.

This meant we could not be sure people received personalised care and support which was specific to their needs or preferences. The lack of guidance on how staff should be providing care to people could lead to inconsistencies in care provision.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

When we asked the manager about the care plans they said an audit identified the need to update care plans so they were person-centred. Certain staff were given responsibility for updating these. Some care plans we viewed contained detailed information about people's food preferences and interests, but this was not found in all the care plans we viewed. Involvement of family members in people's care planning varied, which meant family members were not always involved in decisions about their relatives' care. When we asked the manager about this they said this was an area for improvement and records confirmed this was discussed at a recent relatives' meeting.

The provider had a complaints policy which was given to people at the start of their care package and was kept in their care records. The manager kept a record of minor concerns and formal complaints. 26 complaints had been made about the service in the last 12 months. Records showed what action had been taken, for example when staff apologised, but some relatives we spoke to said they weren't always satisfied with the outcome. For example, one relative told us they had complained about staffing levels before Christmas 2015 but been told staffing was adequate. A significant number of people told us they had reported to staff they didn't like the new menu. The manager told us they were working on improvements to the menu following these complaints, but there was no timescale for completion. This meant we could not be sure complaints were always dealt with appropriately

There were clear examples of staff responding to people's needs, for example when staff suspected people had an infection the GP was called, but the provider was not always responsive to people's needs. On the ground floor people with residential needs lived alongside people with dementia. Some people who lived on the ground floor told us they were isolated as they found it difficult to socialise with people with dementia, so they stayed in their rooms a lot so they were "out of the way". There were several people who lived on the ground floor whose needs could have been better met on the dementia unit on the first floor. This could also

reduce the social isolation some people on the ground floor felt. When we discussed this with the manager they said they were looking at ways to address this.

The provider employed one activities co-ordinator at the service. Some people and relatives felt one activities co-ordinator was not enough for the amount of people who used the service. One person told us, "I sit about all day because there's nothing else to do." The activities co-ordinator told us a second activities co-ordinator was due to start work the following week, which would help to get more people involved in activities.

An activities timetable was displayed clearly on both floors in written and picture format. The activities co-ordinator organised a range of activities and entertainment, such as quizzes, dominoes and bingo. They were enthusiastic about events they organised, particularly outdoor activities during the summer months. People and relatives spoke positively about this staff member. One relative described the activities co-ordinator as "very personable" and told us they liked it when they were shown photographs of their family member engaged in activities. Another relative told us how they had seen people doing household tasks with the activities co-ordinator such as cooking and folding clothes. The relative said, "There was a buzz of conversation when this was going on. It was a happy atmosphere."

The activities co-ordinator had lots of ideas to increase the range of activities for people, particularly for those living with dementia. For example, they encouraged family members to bring items in to put in memory boxes outside people's rooms. Staff told us they would like access to a vehicle so they could take people on trips to the beach and other places of interest, as some people rarely left the service. One person told us, "I can't get out as I need someone to take me and staff are too busy." This meant people were not always going out when they wanted to because of too few staff.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager but a manager had been in post since May 2015, who had been employed by the provider for many years. We are dealing with this outside of the inspection process. The manager was supported by a deputy manager who had also been in post since May 2015. Both the manager and the deputy manager assisted with the inspection on both days we were there.

The manager told us quality monitoring and audits took place regularly. We reviewed the audits and saw these covered areas such as care plans, medicines and catering. An audit completed in January 2016 identified the need for each person to have a keyworker. A keyworker is a named member of staff who has specific responsibility for the person's care. The manager told us they were in the process of updating care plans as an audit identified they were not specific to the needs of the individual. This had been started recently but there were no agreed timescales for completion.

Whilst the provider had a system in place for auditing the quality of the service, audits had not identified our concerns in relation to staffing levels and Disclosure and Barring Service checks.

Staff surveys were carried out annually, the most recent was completed in September 2015. The results of this survey had not been analysed which meant it was not clear what the feedback was and whether actions needed to be taken. This meant the provider did not always respond to staff feedback in a timely manner.

This is a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Staff meetings were held several times a year. The last staff meeting was held on 22 December 2015. There was no list of attendees or a review of minutes and actions from previous meetings.

Resident and relatives' meetings were also held several times a year. The minutes of one meeting in the last year showed the manager had asked residents if they were interested in being on a recruitment panel, should they recruit new staff in the future. Three residents said they would like to be on such a panel. This meant residents could be involved in the selection process of new staff. Although minutes of these meetings contained a list of attendees, there was no review of minutes and actions from previous resident and relatives' meetings, so it was not clear if action had been taken.

Staff said they felt supported by the management team. One staff member told us, "The managers are excellent and very supportive." Another staff member said, "The managers are brilliant, they listen and offer support." Staff told us they enjoyed their work, but thought the service could be improved if there were more staff. Staff felt the quality of care was suffering because of a lack of staff.

We asked people and relatives for their views on the manager. One person told us, "The manager is nice. Nothing's a bother to her or any of the staff." A relative said, "The manager is trying hard but there are lots of things to change. Both the manager and deputy manager are very experienced." A representative of the

speech and language team told us, "The manager is knowledgeable about the residents and the service."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care plans were not specific and did not reflect their individual care needs. Regulation 9(3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's audit procedures did not always identify areas for improvement and where they did clear timescales were not always identified. The provider had not responded to staff feedback in a timely manner. Regulation 17(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 did not have sufficient numbers of staff on duty to deal with the needs of people who used the service. The provider failed to ensure staff were trained to meet the needs of the people who used the service. Regulation 18 (1)(2)(a)(b)