Strathmore Care

Whittingham House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Whittingham House is a care home providing accommodation for persons who require nursing or personal care for up to 70 people including people living with dementia. At the time of our inspection, 59 people were living at the service.

People's experience of using this service and what we found
The provider had not identified or managed health and safety risks and hazards. Risks were not always safely monitored or managed, for example risks relating to falls, moving and handling, distressed reactions and eating and drinking. A lack of information and follow up across people's care plans meant people were at risk of harm. Systems in place to protect people from the risk of abuse were not effective. The provider had not always reported concerns to external agencies, such as the local authority and CQC where required. Whilst we found medicines were administered safely, we found medicines were not safely secured and other minor improvements were required. Staff were deployed to meet people's needs but were often task focused.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Capacity assessments had not always been completed, and conditions on Deprivation of Liberty authorisations had not been met. People's needs and choices were not always updated in care plans to reflect current needs.

The providers quality assurance systems were not effective. Whilst some audits were being completed, they did not identify any of the concerns found at this inspection. There were also no effective checks at provider level. We received mixed feedback about the culture of the service from staff.

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

The last rating for this service was good (published 04 June 2021).

Why we inspected
We received concerns in relation to safeguarding staffing and poor care. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
The overall rating for the service has changed from good to inadequate based on the findings of this inspection.
We have found evidence the provider needs to make improvements. Please see the safe, effective and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Whittingham House on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to risk, safeguarding, consent, meeting nutritional needs and governance at this inspection.

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? The service was not safe. Details are in our safe section below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective section below.	**Requires Improvement**
Is the service well-led? The service was not well led. Details are in our well led section below.	**Inadequate**

Whittingham House

Detailed findings

Background to this inspection

TThe 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team was made up of 2 inspectors. An Expert by Experience carried out telephone calls to relatives following the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Whittingham House 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. Whittingham House 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 not a registered manager in post. An interim manager was in post who left shortly after the inspection. A new interim manager is now in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 6 June 2023 and ended on 15 June 2023. We visited the service on the 6 and 7 June 2023.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We 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 7 people who used the service and spent time talking to people and observing care delivery in communal areas over the 2-day visit, including lunch time observations. We spoke with 9 staff members including the interim manager. We looked at 14 people's care records and multiple medicine records. We looked at records relating to safeguarding, accidents and incidents, quality assurance systems, recruitment and safety records, including records relating to premises and equipment. Following our site visits, we spoke with 10 relatives by telephone.

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 good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• The provider's arrangements to identify unsafe health and safety matters were not effective. Chemicals were not stored safely and could have serious consequences for people if ingested or swallowed. We found 3 occasions rooms containing chemicals were not secured appropriately. Two of these occasions were after informing the management team of the first occasion.
• We also identified on 3 occasions sluice rooms were left unlocked. The hot water in sluice rooms is not controlled this meant this room could be accessible to people living on the first floor and older and frail people are more at risk of serious injury from scalds or burns.
• Risks were not always safely monitored or managed. We observed poor staff practice in relation to moving and handling.
• One person was being transferred by 2 staff members using a standing hoist. We observed the person was very lethargic and appeared unable to follow instruction from the two staff members. Staff continued to transfer when it was clear the person was unable to stand, weight bear or follow instruction. This resulted in a poor transfer, once transferred into a wheelchair the inspection team noticed the person's right foot was not on the footplate of the wheelchair and had to stop the staff member from moving the wheelchair due to the danger of the person's foot becoming caught and causing an injury. This incident was subsequently reported as a safeguard.
• Risks associated with people's individual care and support needs were assessed and recorded to make sure people were safe. However, these did not always detail or provide appropriate guidance for staff to follow. For example, there had been a high number of unwitnessed falls and whilst a falls risk assessment was in place, information in relation to equipment such as sensor mats was not always included in other parts of the care plan such as the mobility plan or sleeping plan to ensure staff had the correct guidance in place to follow.
• Body maps found in care plans did not provide any updates or information in relation to wound care or healing. We identified other injuries to people that had not been followed up. 1 where we could not find an accident form and another where a significant injury had been described on the accident form as minor.
• Some people had incidents of distressed behaviour. ABC charts had been completed for several incidents. (An ABC chart is an observational tool that allows us to record information about a particular incident. The aim of using an ABC chart is to better understand what the distressed reaction is communicating.) However, there was very little information about what may have triggered the incident or what methods staff had used to support people.
• Some people had been identified in their care plans as being at risk of malnutrition or dehydration. Risk assessments recorded monitoring of food and fluids was required. However, we found fluid charts amounts did not always meet the targets recorded within care plans. There was no action recorded to identify what staff were doing in response to these low recordings.

Using medicines safely
• We were not assured medicines were safely secured. During the inspection the medicine keys including controlled drugs cupboard keys were left in an unlocked drawer at the care station in the main lounge. This care station was often left unattended.
• Items not related to medicines such as purses, a person's false teeth and raffle tickets were stored in a cupboard containing medicines. This cupboard was for particular medicines and should only be used for the storage of these medicines. No other items should be placed there.
• Codes used to record 'as and when required' (PRN) medicines were not consistent. Some staff were using the code 'N' [not needed] whilst others left the medicine administration record blank when not needed. This meant staff were not using a consistent method for the recording of PRN medicines.

Systems were not effective to assess, monitor, and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

• Other aspects of the management of medicines were effective. Medicines administration records (MAR's) were completed, and a sample of medicines we checked reconciled.
• The interim manager told us they had worked hard to ensure medicines management was improved.

Systems and processes to safeguard people from the risk of abuse
• We were not assured the provider had an effective system in place to ensure allegations of abuse and neglect were shared appropriately with the local safeguarding team.
• The local authority had recently visited and identified several accidents and incidents that had not been reported appropriately to safeguarding authorities. These were reported retrospectively.
• During this inspection we found a further two incidents where injuries had occurred that had not been reported to either the safeguarding authorities or CQC. These were reported by the interim manager following this inspection.

Systems and processes were not operated effectively to protect people from abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Most people and relatives told us they felt safe. One person told us, "They always come and check I am okay." A relative told us they felt their [family member] was safe at the home. They said their family member walks with a walker and has had a couple of falls. The relative had no concerns how the home dealt with it and the home contacted them straight away.

Staffing and recruitment
• During the inspection staff were deployed effectively to meet people's needs. However, interactions between staff and people throughout the inspection were limited and whilst some interactions were positive, they were mainly task focused.
• People we spoke with told us there was enough staff. One person told us, "There is usually staff around if we need something." Another person said, "Staff do come when I call."
• There was mixed feedback from relatives in relation to staffing. A relative told us it was often difficult to get in the home as staff were very busy and said, "They [staff] are run ragged, it's a shame to see." Another relative said they were happy with the care. They felt they had enough staff as there always seemed to be care staff around.
• Prior to staff starting work at the service all necessary pre-employment checks had been undertaken. This helped ensure they were suitable to work with vulnerable people.

Preventing and controlling infection
• The service was very clean; however, we found some aspects of the environment required improvement to ensure cleaning would be effective to reduce the risk of avoidable harm from the spread of infection.
• Not all bathroom and toilets contained foot operated bins. Foot operated bins offer a more hygienic way of disposing of waste as no contact is required with the bin or bin lid.
• Continence aids were being stored on the floor in a communal bathroom.
• In one bathroom on the first floor the enamel was chipped in the bath. In another bathroom on the first-floor tiles were missing and people's personal clothing was folded on the bath chair.

Visiting in care homes
• People and relatives were happy with visiting arrangements.

Learning lessons when things go wrong
• There were not always systems in place to ensure lessons were learnt when things went wrong, and where systems were in place, action was not always taken to mitigate the risk of the same thing happening again.
• There was an accidents and incidents log with analysis. However, there was limited evidence to show this information was reviewed effectively to identify potential themes and trends to help prevent a recurrence.
• The service was working towards improvements with the local authority.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
• DoLS conditions were not always being met. For example, 2 people had a condition on their deprivation of liberty authorisation to complete an MCA for bedrails to evidence these were being used in the person's best interest. We found neither person had an MCA for this.
• Another person had a condition for staff to record all episodes of them asking to leave the home. This condition was not included in the person's care plan so we could not be assured all staff were aware of this condition. The care plan did not contain any records of this nature.
• Another person had a condition to ask the GP to refer the person to community mental health team for formal diagnosis. We could not find any evidence this person had been referred.
• Mental capacity assessment or best interest decisions were not always in place for other restrictions applied to people's freedom. For example, for people who had alert mats beside their bed or covert medicines, there were no MCA or best interest decision in place to demonstrate these decisions had been made in a person's best interest.

The principles of the MCA were not always followed. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Supporting people to eat and drink enough to maintain a balanced diet
• Where people required staff support to eat and drink, this was not always provided in a supportive manner. We observed a staff member supporting 2 people to eat. One person did not appear to be fully alert and

despite this the member of staff continued to try to assist them to eat. At one point the person's head tilted downwards and when the spoon of food was placed to their mouth, they were observed to resist and turn their head to the side. The staff member continued to press on with their task.
• The staff member then left without explanation to assist another person. This staff member was observed to stand over the person they were assisting, instead of sitting at the same height as the person being supported. This meant the member of staff was not able to face the person, provide good eye contact and ensure the person was able to eat at their own pace. A senior staff member told the staff member to sit beside the person, however, the staff member continued the task whilst standing.
• Pureed food items were blended separately to improve the appearance and enable people to taste each item of food. We observed 2 people receiving a pureed meal, a member of staff mixed the food together before assisting people to eat. This meant they did not have the opportunity to taste food items separately.
• One person was trying to stand up during the meal, a staff member continually asked them to sit down.
• Not all people's nutritional needs were being met in line with their care needs or care plan.
• People had been identified at risk of malnutrition and hydration; monitoring charts as described in the safe section were poor.
• In 3 people's care plans it had identified they required support with their nutritional intake. Over a period of 9 days there were numerous occasions when staff had not recorded their food intake.
• On the training matrix most staff training for food and fluids recorded staff were 'in completion period'.

People were not always supported with their nutritional needs effectively. This demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 201

Staff support: induction, training, skills and experience
• Systems were not in place to ensure all newly employed members of staff had received a robust induction. Where inductions were in place these were not always recorded, and induction paperwork was often left blank. There was no evidence in staff files staff had started or completed the care certificate. However, staff reported they had received an induction.
• We were not assured all staff had received training necessary to meet people's needs. The manager provided us with a training matrix which recorded for some staff that training was in progress.
• Staff told us they did not receive regular supervision. One staff member told us, "I cannot remember when I last had this, but my appraisal is due this week." Another staff member said, "I am not having regular 1 to1 meetings."
• Staff told us they did feel supported by the interim manager and deputy manager. One staff member said, "I feel supported and valued by the manager and deputy manager but not by the organisation. "The new manager is very nice and is trying to get things done."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs and choices were not always updated.
• Some people's care plans had limited detail about their individual needs and choices, or how care should be provided in their best interest.
• In one care plan for a person whose first language was not English it recorded staff used flash cards and google translate to communicate. Staff told us they were not aware of any flash cards or google translate. The interim manager confirmed these communication methods were no longer used as family had reported that they were not communicating well in their own language. The care plan had not been updated.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Staff supported people to access healthcare services.
• There was evidence in care plans people had been supported to access healthcare professionals when

needed.

Adapting service, design, decoration to meet people's needs
• The service was over two floors and had large communal spaces people could use. Most aspects of the building were in good order. However, some work was required in communal bathrooms as recorded in the safe section.
• People could personalise their bedrooms and they had access to outside space.

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 good. 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; 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 a registered manager in post, however an interim manager was working in the service who had only been in post since February 2023 subsequently left following the inspection.
- The provider failed to implement systems and use them effectively, to monitor and improve the quality and safety of care provision in the service. We were not provided with any evidence of provider oversight.
- We found limited information was available to demonstrate the arrangements to identify unsafe health and safety matters such as COSHH storage, protecting people from the risk of scalds and burns or safe medicines storage.
- Checks and audits undertaken at manager level had failed to identify the shortfalls we found at this inspection, including in relation to risk management, care plans and care practice, accident and incident analysis, safeguarding, the principles of the mental capacity act and staff induction and support. Audits available did not contain any information about whether any concerns identified had been followed up or actioned.
- There was no analysis of ABC charts to identify and improve the records staff were making. This meant we could not be assured information was either being checked or used to explore and examine patterns, trends and lessons learned, in order to reduce the risk of reoccurrence.
- The training matrix had not been updated so we could not be assured all staff had received all their training.
- Following a visit from the local authority which identified that some safeguarding incidents had not been reported and were referred retrospectively, we identified occasions where statutory notifications had not been sent to CQC. Providers must inform CQC of all incidents that affect the health, safety and welfare of people who use services. Following the inspection some of these were submitted.

Robust and effective governance systems to monitor the safety and quality of people's care and welfare were not effective. This placed people at significant risk of harm. This was a breach of regulation 17 (Good Governance) 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

- During our observations people had limited opportunities to engage in activities of interest. The television

was on, but people did not appear to be watching. One person had a colouring book but was not given any colouring pencils to use. Other people were asleep and disengaged with their surroundings. A member of staff was observed to talk with each person in turn, waking some up to ask if they wished to colour a colouring book or to look at a magazine, most people declined. We did not observe any other meaningful activities taking place during our inspection.

• We received mixed feedback about the culture of the service from staff. Anonymous information was received prior to the inspection there was bullying amongst the senior staff to care staff.

• One staff member told us, "There is a lack of support from the provider and there has been too many managers at the service. The manager is very nice and is trying to get things done." They added whilst they felt valued by the new manager and deputy manager, but they did not feel valued by the organisation. Another staff member said, "The overseas staff are lovely, but I feel they are given too many responsibilities. Staff disappear when the provider visits and the atmosphere in the home changes. Some staff feel the provider is not approachable."

• Other staff comments were more positive and included, "[Senior staff member] is my mentor and is very supportive. All the staff here are supportive and I can talk with [new manager] about anything" and, "I like it here, staff are good. I get on with the [new manager]. They are very approachable and made some good changes."

• A relatives meeting had been held in January 2023; however, we received mixed feedback from relatives about communication. One relative told us, "There is a breakdown of communication and no feedback from the home about what is happening." This relative added if they did not repeatedly ask what was happening, they felt their family member might get left by the wayside." Another relative told us there could be improvements with communication. Their family member was waiting for an update in relation to their family member and they were not getting any feedback from the home about what was happening. Other relatives told us the home kept them informed of any changes or incidents with their family members. We informed the manager about the individual concerns.

• Relatives were positive about care staff supporting their family member. One told us, "Staff are very good, and they work hard. They're always smiley and greet me like a friend." Another relative said, "They [staff] seem to be quite caring, there's good food and the staff are good."

• Staff had regular meetings and supervision to share information and ideas on the development of the service.

Continuous learning and improving care; Working in partnership with others

• The service worked with others, such as the Local Authority and other healthcare professionals.

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 11 HSCA RA Regulations 2014 Need for consent The principles of the MCA were not always followed. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 Systems and processes were not operated effectively to protect people from abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not always supported with their nutritional needs effectively. This demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 201

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 Systems were not effective to assess, monitor, and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Robust and effective governance systems to monitor the safety and quality of people's care and welfare were not effective. This placed people at significant risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice