JK Healthcare Limited

Weald Hall Residential Home

Inspection report

Weald Hall Lane
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Ratings

Overall rating for this service	Inadequate
Is the service effective?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

We carried out an announced comprehensive inspection of this service on 28 and 29 July 2015, at which breaches of legal requirements were found. These included concerns about how staff were trained and how they supported people with their mobility, health and nutrition. Medication was not always safely managed and there was a lack of understanding about consent. People told us that their complaints were not always responded to and there were limited processes in place to assess and monitor the quality of the service.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to the breaches of regulation. We undertook a responsive inspection on 22 October 2015 to check that they were following their plan and to confirm that they now met the legal requirements in relation to Effective and Well Led.

This report only covers our findings in relation to Effective and Well Led. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Weald Hall Residential Home on our website at www.cqc.org.uk.

Weald Hall Residential Home is registered to provide accommodation and personal care for up to 39 older people. The service mainly provides care to people living with dementia. There were a total of 36 people using the service at the time of the inspection.

The home has a registered manager. 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.

Summary of findings

At our last inspection we found that induction training and support provided was not effective as staff were not suitably skilled and knowledgeable. At this inspection we found that additional training had been provided, and improvements had been made. Staff communicated with people well and had a better understanding of the needs of older people and how risks should be managed. Consistency however remained an issue as the oversight arrangements were not working effectively

At the last inspection we found that the provider did not have appropriate arrangements in place regarding consent. We found that some improvements had been made but staff still had limited knowledge and understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), which meant that consent was not always fully considered.

At the last inspection we found that people were not protected from the risks of inadequate nutrition and hydration. We found that some changes had been made but staffing levels impacted on the ability of staff to provide the levels of support that people needed.

At the last inspection we found that people's health needs were not always promoted, and staff were not always clear about how they should support people with specific health conditions such as pressure ulcers and diabetes. We found that improvements had been made and staff were more alert to the risks of deterioration and there were monitoring systems were in place. The arrangements in place would be further strengthened with up to date and clear care plans.

At the last inspection we found that the provider did not have an effective system in place monitor quality and identify, assess and manage the risks. We were told that the provider had started to develop a system but we found that it continued not to be fully operational and therefore we were unable to make a decision about how effective it could be. The concerns which were identified at this inspection had not been identified by the registered person.

We found that there were a number of continued breaches in the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and you can see what action we have told the provider to take at the back of the full version of the report.

The overall rating for this provider remains 'Inadequate'. This home was placed into 'Special measures' by CQC following the last inspection. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service effective?

Requires improvement

This service was not consistently effective.

People were supported by trained staff who did not always work in a consistent way

The principles of the Mental Capacity Act were not fully understood

People were positive about the meals provided but staffing levels and dependency impacted on staffs ability to provide the support that people needed.

People were supported with their health needs

Is the service well-led?

Inadequate

This service was not well-led.

Leadership was visible and supportive but poor practices were not being identified and addressed.

Audits did not address the inconsistencies in the approach of staff or promote individualised care.

Weald Hall Residential 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 on the 22 October 2015 and it was unannounced. The inspection team consisted of two inspectors.

Prior to the inspection we reviewed the information we held about the service and safeguarding concerns reported to us. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect. The information also included any statutory notification that had been sent to us. A notification is information about important events which the service is required to send us by law.

As a number of people who lived in the service had dementia 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.

We spoke with three people and four visitors. We spoke with five staff, the manager and the provider. We looked at people's care records, staffing rotas and records relating to how the safety and quality of the service was being monitored.

Requires improvement

Is the service effective?

Our findings

At our comprehensive inspection of Weald Hall Residential Home on 28 and 29 July 2015 we found that the provider was in breach of regulation, 18, 11, 12 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were concerns about how people's health and nutrition was supported, staff knowledge and the implementation of the principles of the Deprivation of Liberty Safeguards (DOLS.)

At this inspection we found that some of the problems we had previously identified about the organisation of meals and levels of support had not been resolved. We observed lunch in the dining room and found that staff were not available to support people with eating as they were engaged in assisting people to mobilise and taking them to the bathroom. Because of the levels of dependency, staff took considerable time to move people to the dining room and some people had left before others had arrived. Some people ate well but others left before pudding was served or refused what was offered. Staff did not have the time to sit and engage with people and offer encouragement.

People told us that the food was good. The meals served at lunchtime looked and smelled appetising and we saw that there was little food waste. We observed a member of staff assisting one person to eat and this was undertaken in an appropriately paced way.

The home used the Malnourishment Universal Scoring Tool (MUST) to identify people at risk of not eating and drinking enough. We saw that they had given individuals a score based on this tool, and people that were identified as being risk were being weighed fortnightly. However staff did not have a system for monitoring the weight of those individuals in bed, some of whom had been identified as high risk. We saw that referrals had been made to the dietician and advice had been provided, however this information was not always transferred into the care plan and therefore was not always followed by staff. For example advice had been given, to give one person, milk, homemade milkshakes, snacks and food fortification but we could not find records of this advice being followed

We looked at four fluid charts over a period of a week to see how staff monitored people's fluid intake. These showed people were regularly encouraged to drink throughout the day and had good intake. However there was nothing recorded after five o'clock in the evening until the next day. Staff told us that some people went to bed from 6pm and we could not see that these individuals received any food or snacks in the evening. The manager subsequently informed us that drinks and snacks were available. We could not see how the service monitored flood and fluid in the evening for those individuals who had been identified as at risk.

This is a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC is required by law to monitor the operation of the Deprivation of liberty (DoLS) and The Mental Capacity Act (MCA) which provide legal safeguarding for people who may be unable to make decisions about their care. At the last inspection we found that the principles of the MCA code of practice had not always been followed.

At this inspection we saw that some capacity assessments had been undertaken and a review had been undertaken of the use of bedrails. As a result the numbers of people with this type of restrictive equipment had been reduced. Staff however continued not to have a full understanding of capacity and how this impacted on care delivery but told us that further training was planned.

Concerns had previously been identified about the skills and knowledge of staff. At this inspection we found that additional training had been provided and there had been some improvements to how staff related to people using the service and undertook their duties.

We spoke with two new staff who told us that their induction had been thorough and they had worked on a supernumerary basis observing colleagues before working independently. They told us that they had been supported and were working towards the care certificate. This is a new framework for staff induction which enabled staff to demonstrate their skills knowledge and competence. Other longer serving staff had also undertaken training and one member of staff told us, "I now know what a moisture lesion is and how the different creams and sprays work to protect people's skin."

Staff had a better understanding of the needs of people with dementia and awareness of people's previous experience and the potential impact. One member of staff said, " I love listening to peoples stories." Communication between staff and people was more effective and we

Requires improvement

Is the service effective?

observed that staff maintained eye contact when they spoke with people and interactions were warm. Staff were attentive and asked individuals if they were comfortable. We observed two staff singing to an individual as they were assisting them. They told us that the individual responded positively to singing and this reduced their anxiety. We observed that the individual sang along with staff and cooperated with them as they were being assisted.

At the last inspection we found that the training in moving and handling was not effective as staff were not familiar with the moving and handling equipment placing people at risk of injury. At this inspection we observed some improvements but practice was not consistently good. Staff were more confident in using the equipment and were using individualised slings. However we continued to have some concerns about the use of the stand aid with individuals who had difficulty weight bearing. We observed staff assisting people to mobilise and it was positive that people were encouraged to be as independent as possible. However we did observe two staff assisting an individual using an underarm lift which indicated that staff were not always putting their training into practice and the management oversight was not effective.

Staff knowledge of infection control procedures had improved since the last inspection. Soiled mattresses had been identified and replaced and staff were more alert to the risks. They were observed using different cloths to clean designated areas, thereby reducing risks of contamination.

At the last inspection we found that people were not always supported to maintain their health. The arrangements in place to support people and manage the risks associated with diabetes, catheters and pressure ulcers were not clear or effective.

At this inspection we found some improvements. The systems in place to manage the risks associated with pressure care were more effective and staff were clear about their responsibilities. We observed pressure relieving mattresses and cushions in use and the settings were being monitored. There was guidance for staff to follow on supporting people with diabetes and catheters. However we found that care plans were not always up to date or were contradictory for example stating an individual had allergies but that they did not in another section. This lack of clarity meant that staff were not always clear about what actions they needed to take to meet people's needs.

Inadequate

Is the service well-led?

Our findings

At the last two inspections we found significant shortfalls in the way that the service was led and a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to good governance as the leadership was not proactive and there were limited processes in place to assess and monitor the quality of the service. Following the inspections the provider told us that monitoring was being undertaken and the quality of care had improved.

At this inspection we found that staff had received training and they had a greater knowledge about the care of older people. However we continued to have concerns about how the homes management ensured that staff were putting their training into practice and working in a consistent way. The manager told us that formal, direct observations had been introduced to assess competency but was only able to show us one brief assessment.

Staff were positive about some of the changes that had been introduced such as the new life stories but said that there was now a big increase in paperwork. They did not recognise the link between the documentation and care delivery. They did not know what happened to the paperwork that they completed, for example they could not tell us who evaluated fluids and how much people should be drinking.

The majority of people using the service could not tell us about their experiences or help to influence the service delivery. The provider did hold resident meetings but we could not see evidence that they had adequate ways of engaging with people and making a judgement about the standard of care people received. Through our observations we saw that staff were busy, sometimes rushed and people were largely disengaged and did not have enough stimulation or activity. There were activities provided but these were attended by only a small percentage of people and others spent a large part of the day asleep.

Routines were rigid and staff led rather than centred around the needs of individuals. For example there was a bath board identifying that people should have a bath once a week and we did not see that they had the option of a shower or more frequent baths. We observed one individual asking for a drink but was told that they had to "wait until coffee time." People were assisted to bed after 6.00pm but we could not see that this was the individual's choice. We asked staff whether people could stay up later and were told that people who were independent may choose to.

The provider carried out audits but these were not always written up and when they were the evidence was not sufficient to draw any conclusions. The evidence did not highlight how many people had been spoken with, what care was observed or if any specific issues had been identified. The manager told us they worked along staff and observed the care provided but did not have any evidence to show us. They did not for example carry out dining experience audits or activity audits to ensure what they were doing were appropriate to the needs of people using the service. We were told that care plans had been audited and no issues had been raised. However when we looked at care plans we found that they were not up to date and contained contradictory and confusing information. They did not help staff know that people's needs were and staff told

us that they did not contribute to or generally use them.

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

The manager told us that they had recently completed training with My Home Life. This training was overseen by the Local Authority and its aim was for home managers to support each other and share good practice. The manager told us that they had found this training helpful. The manager was aware of other local initiatives including a friends and neighbours scheme which tried to identify volunteers to spend time with people living in the home and match them with people with similar interests

Regular staff meetings were being held and we were shown minutes of a recent meeting where reminders were given to staff about expectations. Further recruitment was underway to build on the staff team and we were told that there were plans to develop staff skills and give staff additional responsibilities to "champion good practice. "

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs We found that the registered person had not ensured that people were protected from the risks of inadequate nutrition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person did not yet have an effective system or process to assess and monitor the quality of the service and manage risks.

This section is primarily information for the provider

Enforcement actions

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