Akari Care Limited

Wheatfield Court

Inspection report

Wheatfield Road
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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 17 July 2017 and was unannounced. A second day of inspection took place on 19 July 2017 and was announced.

Wheatfield Court is a residential home which provides nursing care, personal care, short term care and reablement (short term support usually after people are discharged from hospital) for up to 60 people. At the time of our inspection there were 57 people living at the home, some of whom were living with dementia. 34 people were receiving nursing care, three people were receiving residential care and 20 people were receiving short term care on the reablement unit which is located on the first floor. All bedrooms have en-suite facilities. Some bedrooms on the ground floor have direct access to the garden.

A registered manager was not in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The current manager has been in post since April 2017 and has applied to the Care Quality Commission to become the registered manager.

We last inspected this service on 23 March 2015 when it was rated 'good.'

During this inspection we found breaches of Regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because: risks associated with people's care were not always identified and mitigated; essential staff training was not up to date; the provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure people received appropriate care and support; and the provider had failed to notify the Commission about significant events in a timely manner.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Medicines were not always managed safely as there was a lack of guidance for staff in relation to 'when required' medicines. When people had their topical creams administered this was not always recorded accurately.

People we spoke with told us they felt safe living at the home. Relatives we spoke with all said they felt their family members were safe.

A thorough recruitment and selection process was in place which ensured staff had the right skills and

experience to support people who used the service. Identity and background checks had been completed which included references from previous employers and a Disclosure and Barring Service (DBS) check.

Each person had a personal emergency evacuation plan (PEEP) which provided staff with information about how to support them to evacuate the building in an emergency situation such as a fire or flood.

There were enough staff on duty to meet people's needs. The provider was using agency nursing staff while they recruited to fill five nurse vacancies. Essential staff training was not up to date.

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

Fluid charts had not been completed accurately. People said the food was enjoyable.

Staff were not always caring as sometimes they concentrated more on the task rather than the individual they were supporting. People gave us positive feedback about the standard of care provided.

People had access to important information about the service, including how to complain and how to access independent advice and assistance such as an advocate.

Some care plans lacked personal information about how people needed and wanted to be supported.

People's risk of social isolation was increased as they did not always have frequent access to meaningful activities.

People who used the service spoke positively about the manager and said the service was well-led.

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 always safe.

People were put at risk of pressure damage as pressure relieving mattresses had not been used correctly.

The guidance for staff on 'when required' medicines was not always clear. Record keeping in relation to topical medicines was not robust.

Thorough background checks had been carried out before staff began their employment.

Staff understood their responsibilities in relation to reporting safeguarding concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Essential staff training was not up to date.

Fluid charts were not completed correctly.

People received a varied and balanced diet. Support was provided for people with specialist nutritional needs.

The provider supported people in line with requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement

The service was not always caring.

Some staff were task-focused and did not always identify or respond when people had spent a long time alone.

People gave us positive feedback about their care and told us staff were kind and caring.

Relatives spoke positively about staff and the service.

People were given information about the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans lacked detail about how people needed to be cared for.

People did not always have access to appropriate activities.

People had information about how to complain.

Complaints were dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

The provider's quality assurance system had not identified all of the concerns we identified during this inspection.

The provider's lack of effective monitoring had placed people at risk.

The provider had not made timely notifications to the Commission.

Staff said they had enough opportunities to provide feedback about the service.

Wheatfield Court

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 17 and 19 July 2017. Day one of the inspection was unannounced which meant the provider did not know we would be visiting. Day two was announced so the provider knew we would be returning. The inspection team was made up of one adult social care inspector, a specialist nurse advisor with expertise in tissue viability (how to prevent and treat skin pressure damage) and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

We also contacted the local authority commissioners for the service, the local authority safeguarding team, the clinical commissioning group (CCG) and the local Healthwatch to gain their views of the service provided. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We did not receive any information of concern from these agencies.

During the inspection we spent time with people living at the service. We spoke with 16 people and 12 relatives. We also spoke with the manager, a representative of the provider (regional manager), three nurses, two agency nurses, 12 care assistants, the activity co-ordinator, two maintenance staff, two kitchen staff and two domestic staff.

We reviewed seven people's care records and four staff files including recruitment, supervision and training information. We reviewed medicine administration records for 11 people as well as records relating to the management of the service. We also checked the building to ensure it was clean, hygienic and a safe place

for people to live.

Requires Improvement

Is the service safe?

Our findings

Risks associated with people's care were not always identified and mitigated. For example, there were eight out of twelve people who had an airflow pressure relieving mattress in place which had been set to the wrong setting for their weight. There was no information about what setting mattresses should be on in people's care records which placed people at risk of pressure damage. This had not been identified by staff or management. When we spoke to the manager about this they immediately reviewed everybody who needed a pressure relieving mattress to ensure they were at the correct setting and the setting was documented in care records.

One person did not have the use of an appropriate mattress. Their bed consisted of two stacked mattress overlays. Mattress overlays are designed to give additional pressure reducing qualities to an existing standard mattress and should always be used in conjunction with another mattress and not instead of a mattress. Whilst no harm had resulted, this person should have been given a standard high specification foam mattress or a standard mattress with this overlay on top. When we raised this with the manager they said they would ensure the right mattress was supplied as soon as possible.

People did not always receive the care they needed to help keep them healthy. Records of positional changes for people at risk of skin damage had not been kept. Staff told us how often people needed to be turned to reduce the risk of pressure damage but charts to record this were not in place. This meant people who had been assessed as at high risk of skin damage were placed at a greater risk as we could not be sure people had been turned when they should have been.

Medicines were not always managed safely. Some people took medicines 'when required', such as painkillers. There were not always detailed guidelines for staff to follow which explained when a person may require these medicines. For example, what signs or symptoms a person may display if they were in pain and not always able to communicate their needs. Staff described when they would administer 'when required' medicines but there was no clear guidance for them to refer to. This meant people could be at risk of not receiving medicines when they needed them, particularly those who could not always communicate their needs.

Topical medicines application records (TMARs) and body maps to highlight where staff should apply prescribed creams and ointments were in place, but records relating to topical medicines were incomplete. Staff told us where people's creams needed to be applied and how often, but incomplete records meant we could not be sure prescribed creams had been administered in the right way or at the right frequency, in line with the instructions on people's prescriptions.

Three people did not have photographs on their medicine records. This increased the risk of mistaken identity when staff administered medicines. As the service was currently using high numbers of agency staff this risk was particularly relevant.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

The service operated a monitored dosage system (MDS) for administering routinely prescribed medicines, with medicines supplied on a seven day cycle. An MDS is where medicines are pre-packaged for each person, according to the time of day. Medicines were recorded as administered on an electronic hand held device. We saw people received their medicines at the time they needed them. We found no gaps in relation to routinely prescribed medicines but there were several occasions when the correct non-administration code had not been used. Staff had occasionally used the non-administration code for 'not in stock' rather than 'not required.' When we spoke to nursing staff about this they felt this was a training issue around the use of the hand held device. The manager said they would ensure all staff, including agency staff, were reminded of the correct codes to use in such circumstances.

Medicines that are liable to misuse, called controlled drugs were recorded and stored appropriately. Records relating to controlled drugs had been completed correctly. The temperature of treatment rooms and the clinical fridges were checked daily and were within recommended limits.

Accidents and incidents were recorded and dealt with appropriately. Action following an incident or accident was evident, for example changes were made to the lighting on one unit when it was identified better lighting could improve visibility and reduce the risk of falls. Regular analysis of accidents and incidents had not been carried out. This meant trends had not been identified where they may have existed and additional control measures to reduce the risks to people could have been implemented. We noticed the manager had recently begun to analyse accidents and incidents for the previous month but this had not been done prior to this.

Health and safety checks were carried out regularly to ensure people's safety. These included fire safety checks, window restrictor checks and regular servicing of equipment used in care delivery such as wheelchairs and hoists.

Each person had a personal emergency evacuation plan (PEEP) which contained details about their individual needs, should they need to be evacuated from the building in an emergency. They contained clear step by step guidance for staff about how to communicate and support people in the event of an emergency evacuation.

People we spoke with told us they felt safe living at the home. One person said, "It's lovely here, I feel safe and well cared for." Another person told us, "Everything is great, it's spot on." Relatives we spoke with all said they felt their family members were safe.

The service employed 62 staff. The registered manager, three nurses, 10 care assistants and one activities co-ordinator, two kitchen staff, one laundry staff, three domestic staff and two maintenance staff were on duty during the days of our inspection. Staff rotas we viewed showed these were the typical staffing levels for the service. The service also employed two administration staff, kitchen staff, a housekeeper, domestics and two maintenance staff. Night staffing levels were two nurses and five care assistants. There were five nurse vacancies at the time of our inspection which had been advertised. Agency nursing staff were being used on a daily basis in the meantime.

People and relatives told us there were enough staff to attend to people's needs. During this inspection we noted call bells were answered in good time so people didn't have to wait too long. People and relatives told us call bells were usually answered as quickly as possible.

Records confirmed most staff had completed up to date training in safeguarding vulnerable adults. Staff understood their safeguarding responsibilities and told us they would have no hesitation in reporting any concerns about the safety or care of people who lived there.

We looked at recruitment records for four staff members who had started to work there since the last inspection. The recruitment practices for new staff members were robust and included an application form and interview, references from previous employers, identification checks and checks with the disclosure and barring service (DBS) before they started to work at the home. DBS checks help employers make safer recruitment decisions by preventing unsuitable people from working with vulnerable people. This meant there were adequate checks in place to ensure staff were suitable to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

The registered provider used an electronic matrix to monitor and record staff training. We reviewed the training matrix and found training in some areas was not up to date. No staff had completed up to date fire safety training or pressure care training and only 22 out of 62 staff had completed up to date training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (known as MCA and DoLS). Wheatfield Court provides care for people who are living with dementia, however only 18 out of 62 staff had completed dementia training.

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

When we spoke to the manager about this they said the training matrix was up to date and they were aware staff training was an issue. The manager told us, and records confirmed, some training had already been arranged to address this. By the end of the inspection training on pressure care and dementia awareness had been arranged although the manager said they had some difficulty finding dementia training for large numbers of staff.

Staff supervisions were not up to date. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. 27 out of 62 staff had not received a supervision every two months this year in line with the provider's policy. The manager told us supervisions were planned for July and August to "get things back on track." Records of supervisions lacked meaningful detail.

We reviewed people's records relating to nutrition. Food and fluid charts were in place for some people but it was not always clear why they needed their food or fluid intake monitoring. Fluid charts were not always completed fully as fluids were not always totalled and there was no daily fluid intake target set. This meant we could not be sure staff knew how much fluid people should have on a daily basis and what action to take if daily targets were not reached, so people were placed at risk of dehydration. People's weight was checked and monitored regularly.

There was a lack of visual or tactile items to engage people living with dementia. Doors to bathrooms were not coloured to identify them as bathrooms, there was a lack of pictorial signage to support people with communication needs. Written menus were in place in the dining rooms but some people who used the service would not have been able to understand these and could benefit from menus in picture format. This meant information was not always provided in a format appropriate to people's needs.

People were supported to access appointments with healthcare professionals such as the GP, podiatrist and optician. Referrals to the falls team, challenging behaviour team and other health care professionals were made appropriately.

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 and hospitals 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. We saw DoLS applications had been made appropriately for people who needed them. DoLS applications contained details of people's individual needs and how decisions made about DoLS were in people's best interests.

We checked to see how people's nutritional needs were met. We looked around the kitchen and saw it was stocked with fresh, frozen and tinned produce. We spoke with the chef and kitchen assistant who were aware of people's different nutritional needs, for example if people required sugar free desserts due to diabetes.

We observed lunch in the dining rooms. The atmosphere was pleasant and relaxed and people were served their food in a polite and respectful manner. We saw staff encouraged people to eat independently where possible but provided support if people needed it. People who required support to eat their meals were patiently supported at a pace comfortable to them. Staff also prompted and encouraged others where needed. Tables were set nicely with place mats, napkins, cutlery, condiments and cups. Where people preferred to eat in their rooms staff respected this.

People commented positively about the food. One person told us, "The food is very nice." Another person said, "There's plenty of food and drinks. I eat better here than I did at home."

Daily multi disciplinary team meetings were held on the reablement unit to discuss people's progress and plan their care. These were very effective in aiding communication across various departments and improved outcomes for people who used the service.

Requires Improvement

Is the service caring?

Our findings

People we spoke with gave us positive feedback about their care. They told us staff were kind and caring. One person told us, "Staff are very helpful and very caring. They always do their best for you". A second person said, "Staff can't do enough to help you." A third person told us, "I can't fault the care or the place. I get one-to-one attention."

Relatives spoke positively about the care provided. One relative commented, "There's a great team of lasses. They all always do their best." Another relative said, "It's an absolutely tremendous place. The staff are absolutely fantastic, the care is second to none. It gives us peace of mind."

The reablement unit had received numerous thank you cards from people who used the service and their relatives.

People received a service that was not always caring. Staff were mainly supportive and respectful but there were occasions when some staff were task-focused rather than focusing on the individual being supported. For example, when supporting people to transfer from the dining room to the lounge staff hardly interacted with the person, whilst others explained what they were doing and made general conversation. Some staff did not reassure people when they needed it or divert people when they became anxious or upset.

On the second day of our visit we saw four people who used wheelchairs sitting in the corridor after lunch. When we asked staff why people were sitting in the corridor they said it was because one of the lounges was being used for a meeting. We noted that other communal rooms were available if people had wanted to use them. It was not the choice of those individuals to sit in the corridor which was undignified.

Some people needed to spend significant periods of time in bed due to their health needs. Whilst people had their physical needs met such as support to wash, dress and eat this took up the majority of staff time. This meant that once people had received personal care there was very limited interaction with staff until they required support with another task.

People were mostly treated with respect. We observed staff interacting with people in a kind manner, but there were occasions when staff knocked on doors before entering but did not always wait for a response before going in.

Each person who used the service was given a residents' guide (an information booklet that people received on admission) which contained information about the service.

Information about advocacy support from external agencies was available. 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 were detailed and mostly personalised. The records were not consistent and could be improved. For example, some care plans did not contain a photograph of the person or any information about a person's likes and dislikes and how they wished to be supported as an individual. Some care plans did not contain information about people's social history and family background. Staff need this information so they could get to know people as individuals.

Some care plans we viewed did not record how a person or their representative had been involved in the care planning process. This meant we could not be sure whether people and their representatives had been involved.

People had limited opportunities to take part in meaningful activities. Records of activities were incomplete and showed that some people did not always have access to regular activities that were appropriate to their needs and preferences. Several people who were cared for in bed had no recorded activities for several days. This meant their risk of social isolation was increased. One person said, "The days can be long and boring."

The service employed one activities co-ordinator who organised events and activities. The activities co-ordinator told us activities included manicures, handbag parties, going to the local church coffee morning, jigsaws, pie and pea suppers, quiz nights and entertainment from local singers. A summer fete was planned for the end of July 2017. The home had a minibus which was used for regular outings but relatives we spoke with felt this could be used more often so more people could get out.

The provider had information for people and relatives about how to make a complaint. People and relatives told us they would speak to staff if they had any concerns about anything. One relative told us, "If there is any issue we just talk to carers or the manager." Two complaints had been received in the last 12 months. Records showed complaints had been dealt with in an appropriate and timely manner.

Inadequate

Is the service well-led?

Our findings

The provider had a quality monitoring or audit system in place to review areas such as medicines, care plans, safeguarding, complaints and health and safety. A recent audit identified some issues relating to health and safety and care plans. However, the provider had not identified all of the areas for improvement we found during this inspection such as pressure relieving mattresses not being set correctly, people's positional changes not being recorded and the administration of topical creams not being recorded accurately.

Whilst people had not suffered any pressure damage as a result of pressure relieving mattresses not being set correctly for their individual weights, their risk of pressure damage was increased. Over inflation and under inflation of pressure relieving mattresses can cause skin damage due to the mattress being too hard or too soft, and can be uncomfortable for a person to use. This meant the provider's quality monitoring system was ineffective in identifying and generating improvements within the service. The provider had not identified that people had been placed at risk of harm.

The provider lacked effective systems and processes to maintain accurate and complete records relating to people's care. This placed people at risk of receiving unsafe or inappropriate care. There was a lack of information in care records to evidence people had received the care they needed to keep them safe. Care plans did not always contain the information required by staff to provide personalised care and support to people.

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

When we spoke with the regional manager and manager about the issues we found during this inspection they took immediate action in relation to reducing people's risk of pressure damage and arranging staff training for the coming weeks.

Services that provide health and social care to people are required to inform the Commission of important events that happen in the service in the form of a 'notification'. The provider had not made timely notifications to the Commission when required in relation to significant events that had occurred in the home. The manager told us a significant number of DoLS authorisations had not been notified to the Commission but they would do so immediately. The majority of these predated the current manager. We are dealing with this outside of the inspection process.

The manager had been in post since April 2017 and had applied to the Care Quality Commission to become the registered manager. The manager was a registered nurse and had worked in the care sector for several years.

People and relatives spoke positively about the manager. All the people we spoke with said the service was well-led. One relative commented, "Staffing has got better since this manager came. She's organised them,

they used to stand around but now they're allocated to designated areas and it's much better." Another relative said, "The new manager seems to know what she's doing so I hope she stays."

Staff mostly spoke positively about the manager although some said there had been a lot of management changes which was sometimes difficult to deal with. One staff member said, "[Manager] is fantastic, really approachable."

Staff meetings were held regularly. Minutes of staff meetings were available to all staff so staff who could not attend could read them at a later date. Staff told us they had enough opportunities to provide feedback about the service.

People and relatives had been asked for their views on the service via a recent survey, but the results of this were not available at the time of our inspection.

Relatives meetings were held regularly but staff told us these were poorly attended. The manager told us she was looking at different methods of seeking feedback from people and relatives.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with people's care were not identified and mitigated, specifically in relation to checks on pressure relieving equipment and records relating to people's positional changes. Records relating to the administration of prescribed topical creams were not accurate. Regulation 12 (2) (a) (b) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not completed up to date training relevant to their job role, specifically fire safety, pressure care and dementia awareness training. Regulation 18 (2) (a)

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 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance processes had failed to identify that people were placed at risk of harm by pressure relieving mattresses not being set correctly, people's positional changes not being recorded and the administration of topical creams not being recorded accurately.

The enforcement action we took:

We have issued a warning notice