Grandcross Limited

# The Wimborne Care Home

**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 caring? | **Requires improvement** |
| Is the service responsive? | **Requires improvement** |
| Is the service well-led? | **Inadequate** |

## Overall summary

This inspection took place on 2 and 5 February 2015 and was unannounced. The Wimborne Care Home provides accommodation and nursing and personal care for up to 29 older people, including people with dementia. There were 25 people living there when we visited. This provider is required to recruit a registered manager for this type of service. The manager had started working in the service in October 2014. At the time of the inspection the manager had applied to become the registered manager of the service. 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 and associated regulations about how the service is run. Prior to this the service had not had a registered manager since the end of 2011.

People, relatives and staff spoke positively about the new manager and told us they were making improvements to the service. People and relatives told us staff were caring and they felt safe living in the service. People's relatives told us the manager and the staff team were approachable and they could talk to them if they had any concerns. There were no recorded complaints or concerns.

Three people told us there were not enough staff and at times they had to wait for assistance.

# Summary of findings

Although people told us they felt safe we found that this service was not providing consistently safe care. We found staffing levels had not taken account of people's needs when deciding on staffing levels which meant people's safety was compromised. We found there were not enough skilled and experienced staff to meet people's needs in a timely way. Some identified risks were not being managed. This meant there was a risk that some people may not receive care to meet their needs and protect them from harm.

People that required support to drink did not always receive it and not all people received care to meet their needs. We raised our concerns with the local authority safeguarding team following our inspection. Not all records about the care provided to people were accurate and there were some gaps in records of care given.

People were not always cared for by staff that treated them with respect and knew how they liked to be cared for. People had access to health care to meet their needs and health professionals told us staff followed their recommendations. However we saw that for one person there had been a delay in a referral being made to a health care professional.

The manager had knowledge of the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. However the manager was unable to tell us if there had been any applications to deprive people of their liberty to uphold their rights.

The systems in place to monitor the service were not adequate to identify required improvements and to protect people from unsafe care. These included the review of incidents and accidents to ensure people were protected from unsafe care. There were limited quality systems in place which meant that some areas of how the service was provided were not monitored. However we saw the manager was responding to improvements identified by the local authority and was starting to address these areas.

The manager told us not all staff had received supervision (one to one meetings with line managers) but they were addressing this. The majority of staff felt supported to carry out their roles and staff received training to carry out their role. Staff were aware of how to recognise and report any concerns of abuse or neglect. The majority of staff spoke positively about the support they received from the manager and other senior staff.

Medicine were stored and administered safely.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to meeting people's needs, staffing and how the service was monitored. You can see what action we told the provider to take at the back of the full version of this report.

# 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 safe?**

Inadequate

The service was not always safe. People and their relatives told us they felt people were safe. However we found that some risks to people were not always managed to keep people safe and there were not enough staff. There were no arrangements in place for staffing levels in the home to be reviewed to ensure that any necessary staff changes were made.

Medicines were stored and administered safely.

Staff had knowledge of safeguarding and knew how to identify and raise safeguarding concerns.

**Is the service effective?**

Requires improvement

The service was not effective. Staff had not received regular supervision (meetings with a manager) However the manager was addressing this and had a plan to carry out supervisions with all staff. Staff received training and to carry out their role and the majority of staff told us they felt supported.

The manager understood the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. However the manager was unable to tell us if there had been any applications to deprive people of their liberty to uphold their rights.

People had access to health care professionals to meet their current and changing needs.

**Is the service caring?**

Requires improvement

The service was not always caring. People that we spoke with and other people's relatives told us staff was caring. However we observed that people were not always treated with respect and compassion.

People and their relatives were involved with making decisions about their care.

**Is the service responsive?**

Requires improvement

The service was not responsive. Relatives told us they were involved in planning of their relative's care. However not all care plans contained personalised information about how people's needs should be met.

There was a programme of activities to meet some people's needs but people cared for in their rooms did not receive regular support and social interaction.

Staff did not always respond to people's needs and staff were not always aware of any changing needs.

People and their relatives felt confident that complaints would be responded to by the manager. There were no records of any written complaints.

# Summary of findings

**Is the service well-led?**

Inadequate 

The service had not had a registered manager in post since 2011 and there had been a number of managers since then.

The systems in place to monitor the service were not adequate to identify required improvements and to protect people from unsafe care.

People, relatives and staff spoke positively about the new manage and told us they were making improvements to the service. We saw the manager was responding to improvements identified by the local authority.

# The Wimborne 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 on 2 and 5 February 2015 and was unannounced. The inspection team included two inspectors and a specialist advisor. We reviewed the information we held about the service, for example notifications and a local authority contract monitoring report.

During our inspection we spoke with the manager, the operations manager, the clinical facilitator, the cook, two registered nurses, six care workers, and one activity coordinator. We spoke with four people who were using the service and two relatives.

We reviewed the care records of four people who used the service, four staff recruitment files, and four people's medicine administration records. We looked at other records relating to the management of the service. This included servicing certificates for the fire safety equipment and system. We undertook general observations in communal areas and during mealtimes. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During and after the inspection we spoke with three health professionals who provided us with information about how the service implemented recommendations they made to meet people's needs.

Inadequate

# Is the service safe?

## Our findings

The service was not safe. There were not enough staff with suitable skills and experience to meet people's needs. Three people told us there were not enough staff. One person told us this meant they had to wait longer to receive personal care and support to get into bed. We observed that two people had been left without their personal care needs being met for a long period of time. Both of these people required support with continence care. Staff told us they did not receive personal care until late morning during our inspection due to their not being enough staff to meet people's needs. Three members of staff raised concern about the delays in assisting people with personal care and the limited time staff could spend with people after meeting people's physical care needs.

We saw that two staff were employed that did not have suitable skills and experience to carry out their roles safely. The manager told us they were not confident in each members of staff's competence or their ability to understand what was required of them. The manager told us that the staff were given instructions by the deputy manager or registered nurse. However they worked alone in the service at times. We observed both staff and were concerned about their competence. For example, one member of staff had not carried out checks on someone who had become unwell. The manager told us they had been asked to. No action had been taken to monitor this person's health or to review the care provided to them. Another member of staff could not answer our questions we asked them about how people were being looked after. This related to how people's needs were met they were looking after. We raised our concerns with the manager during the course of the inspection and informed this had been addressed with the staff.

Six out of 10 members of staff told us they did not think there were enough suitably skilled staff that worked in the service to meet people's needs. One member of staff told us, "We need more staff." They told us this meant that personal care could be delayed and they weren't always able to spend time with people to meet their welfare needs and to keep some people safe. One member of staff told us they had raised these concerns with the manager who was looking at increasing the number of care workers to meet people's needs. Three staff raised concerns about the competency of some staff to carry out their roles and their ability to meet people's needs. For example, staff told us they were not confident one member of staff knew how to meet people's needs. Another member of staff told us they did not feel confident that one person had the required skills and experience for their role.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to some individuals were not managed to keep people safe. One person's risks were not being managed and they were at risk of harm. We looked at the person's care plan and saw that a risk assessment had not been updated to give guidance to staff how to manage their risk of self-harm. Staff were not aware of how to meet the person's needs. We observed the person was distressed and no steps had been taken to limit the risk of self-harm. We raised our concerns with one of the registered nurses, manager and another senior manager on duty on the first day of our inspection. We contacted the local authority safeguarding team to raise our concern. A senior manager told us they would arrange for the person to receive one to one care to manage these risks from the evening of the first day of our inspection. On the second day of our inspection the person was receiving one to one care and appeared calmer. For two other people there were no risk management plans in place providing guidance about how to manage risks. For example, risks for someone who was a risk of skin tears. For another person there was a safe swallow care plan for staff to follow, following advice from a speech and language therapist.

One person had not received care and treatment in response to a deteriorating pressure ulcer. Care records showed the deterioration had been noted two weeks before our inspection. The manager told us the person's pressure sore had deteriorated over the last couple of weeks. They were not clear to what stage it had deteriorated as it had not been formally assessed using a recognised grading system. This meant there was a risk that the person would receive unsafe care as the condition of the ulcer had not been assessed in order to determine the plan of care and treatment. They told us they were cared for in bed for most of the day to relieve the pressure on the ulcer .There had been no referral to the tissue viability service for advice. We raised this concern with the manager

Inadequate

# Is the service safe?

and a referral was made that day. They told us that a pressure relieving cushion for their chair had been ordered to assist with the recovery of the pressure ulcer. The manager told us it had been ordered two weeks prior but there had been a delay due to obtaining quotes for the piece of equipment.

There were inadequate arrangements in place to ensure the planning and delivery of care protected people against the risks of dehydration. People were not supported to be able to drink sufficient amounts to meet their needs. We saw two people who had no ability to communicate verbally and required support to drink to ensure that they were protected from the risks of dehydration. There were no monitoring systems in place and staff were unable to tell us how much people had drunk. On the first day of our inspection one person did not have anything to drink at breakfast as a member of staff said they had been "too sleepy". Care staff were unable to tell us after lunchtime what drinks the person had that morning after breakfast and whether they had been supported to have a mid-morning drink. Two members of staff told us they had been very busy that morning providing care to other people and the person did not receive their personal care until 11.30. We raised our concerns with the manager and deputy manager who asked staff to put fluid and food monitoring charts back in place immediately for people who could not verbally communicate their needs. The manager told us the fluid charts had been taken away the week before as it was decided they were not needed. They told us staff had raised concerns about this decision.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored safely and there were arrangements to record when medicines were administered to people. Medicine administration records contained photographic identification of people and allergies were highlighted on the front sheet of the chart. This meant, steps had been taken to ensure the safe management of medicine. We observed five people being given their medicines. People were given time to take their medicine and the process was unhurried. We saw the member of staff administering the medicines was wearing a tabard marked 'Do not disturb dispensing medication'. This showed us safe practices were being followed.

The records relating to recruitment showed that the relevant checks had been completed before staff started working in the service. These included employment references and checks made on the suitability of staff for roles working in health and social care. We asked the manager about how the concerns were being addressed about the competency and lack of experience of two staff recently employed in the home. They told us the concerns had not been identified at the recruitment stage.

Staff were aware of signs of abuse and of how to report concerns. The majority of staff had completed safeguarding training and their responsibility to record and report any concerns they may have. People and their representatives told us they felt people were safe living in the home.

The building was maintained and regular checks on lifting equipment and the fire detection system were undertaken to make sure they remained safe.

Requires improvement

# Is the service effective?

## Our findings

People gave us mixed feedback about the quality and choice of the food. One person told us, "The food could be better, it is adequate." There were limited choices of snacks during the mid-morning. The options were biscuits and fortified mousse for people at risk of poor nutrition. One person told us they were never offered any fruit and they would like some. We asked for their feedback about the food in the home and they said, "perhaps a bit more variety."

The service was not always effective. Staff did not receive regular supervisions and staff had received training required for their role. People's rights were not always protected as deprivation of liberty safeguards had not been applied for some people where appropriate.

The manager had identified that not all staff had received supervisions (meeting with a manager). The manager told us they had started to carry out supervisions with all staff and they had a plan to complete these. There was evidence that concerns about some staff competencies and practice had been discussed with them and action had been taken to address these concerns. The majority of staff told us they felt supported to carry out their role by the manager and deputy manager. However one member of staff told us they had not felt supported and their role and responsibilities had not been made clear when they started working in the service. Staff had received training specific to their role. This included training on moving and handling, infection control and first aid training. A senior member of staff responsible for supporting staff with their learning needs told us all nursing staff had recently received training to carry out assessments for people at risk of poor nutrition. They said it had been identified as an area that staff required more training and support in. They also told us they had been working with staff on care documentation and had carried out competency assessments of some staff. We saw evidence of this.

The manager was unable to tell us if there were any person was subject to a Deprivation Of Liberty Safeguards (DoLS) authorisation. The safeguards can only be used when there is no other way of supporting a person safely. There were people living in the service who lacked capacity to make a decision to continue live in the service that may require a DoLS authorisation, however there was no evidence an assessment had been carried out. This meant that people's rights may not have been upheld as there was a risk that they were deprived of their liberty unlawfully.

Some staff had an understanding of the Mental Capacity Act 2005. Some people, who did not have mental capacity to make specific decisions for themselves, had their legal rights protected. Best interest decisions involved people's representatives and health care professionals. For example, a best interest decision was made to use bed rails for someone's safety. A 'best interest' decision is made about a specific issue and involves people who know the person and takes into consideration their previous views and beliefs.

People received support to eat their meals. We observed people supported by staff in the conservatory and lounge to have their lunch. We observed another person being supported in their room to have prescribed food supplements in line with guidance from their GP. Advice had been sought from health professionals in response to concerns about some people's weight loss and their meals were supplemented by high calorie meals and supplements. One health care professional told us the recommendations they made to meet one person's nutritional needs were followed through by the staff in the home. The cook was aware of people who required modified diets, such as pureed meals and people who required their meals to be fortified to meet their nutritional needs.

People had access to health care professionals to meet specific needs. Records showed that some people were seen by health care professionals in response to changing needs and management of existing conditions. One health care professional told us staff followed their recommendations and were looking after the person well. However we saw for one person there had been a delay in a referral being made to a health care professional in relation to a pressure ulcer. The manager took action to address this following our inspection.

**We recommend that the provider reviews their systems for checking whether people's rights are upheld in line with current legislation.**

Requires improvement

# Is the service caring?

## Our findings

We observed staff talking to people in a polite and respectful manner. However, some staff spoke about people in front of other people that were not respectful. We heard staff talk loudly in the corridors about people they were caring for. We observed a member of staff come to assist someone with their personal care. They did not acknowledge the person when they came into the room and asked if they wanted a bath or a shower. The person was unable to communicate their wishes. The member of staff told us the person took a long time to answer and the member of staff said, "Sometimes we just have to get on with it." The person received a bed bath. Another member of staff spoke about someone to us using language that was disrespectful and did not show compassion in how the person was supported.

People and their relatives told us that staff were kind and caring. One person told us, "They are very kind, which means a lot" Another person's relative told us staff were caring and said "they are nice to me too." Staff gave us mixed feedback about how people were cared for. One member of staff told us they enjoyed working in the home because staff "are so focused on the people". Another member of staff raised concerns about the delays in some people having their personal care needs met.

Not all staff knew people's preferences or ensured that care was provided that met these preferences. One person told us that they were not always able to go to bed when they wanted to because there was not enough staff. They said, "The carer says you can't go to bed yet." We observed that one person was given drinks that didn't match their preference despite the alternative being available. Another person's care plan stated, "Not able to communicate needs." There was no information or guidance for staff to follow and no communication aids in place to ensure people were involved in their care. Bedroom doors were kept closed when people were being supported with personal care. However not everyone was supported to maintain their dignity. We raised this concern with the manager during our inspection.

People and their relatives told us that they were involved in making decisions about their own care. One person's relative told us the staff had involved them in agreeing how their relative's needs would be met. Another person told us they were involved with how staff supported them to prevent any pressure sores developing.

Requires improvement

# Is the service responsive?

## Our findings

People's needs were assessed prior to them moving into the home and relatives told us they were involved in the planning of their relative's care. Some care records included personal, social and needs assessments. However not all care plans contained all of this information in each person's file, including personalised information about people and how to meet their needs. For example there were gaps in records detailing all of people's needs including how some risks should be managed and people's communication needs. There was a lack of guidance in the care plans of two people for how staff should meet their communication needs and what their interests were. For another person, there was a lack of information about how staff should care for them at the end of their life.

There were gaps in care records used by staff to monitor people's needs. We looked at food and fluids charts for two people and a position chart for another person and found there were gaps, and one position change chart was inaccurate. The chart recorded the person had been supported to move to their chair. We saw they were in bed. There were gaps in records of people's weight who had been assessed as at risk of poor nutrition and whose weight should be monitored weekly. A registered nurse told us they had been weighed but it had not been recorded. We found that two people's records were in the wrong person's rooms. These records contained information about people's creams, charts to record people's movements to prevent pressure sores and food and fluid charts. This meant that there was a risk that people could have received the wrong care.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a programme of chair based activities that some people took part in. We saw some people taking part in a quiz, and an activities member of staff spending time talking to people in the lounge. The majority of people in the home were cared for in bed or chose to stay in their room. There was one part time member of staff employed to co-ordinate and provide activities. They told us they also visited people in their rooms who were cared for in bed. Records showed that people did not always receive this support weekly. One person told us there were some activities in the home that they could join in with but they chose not to. One member of staff told us, "We don't have enough staff for activities."

People did not always receive care and support that was responsive to their needs because staff did not always have a good knowledge of the people who used the service. Two staff we spoke with were not aware of people's needs that we asked them about or did not have an awareness of people's changing needs. For example, we asked one clinical member of staff about someone who other staff members told us had been unwell that day. They were not aware of the person's changing needs and had not carried out any observations in response to changes in their health.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us that they would be happy to raise any issues or complaints. Relatives told us they were welcomed into the home and we observed this during our inspection. One person told us they would speak to the manager if they had a complaint and they would respond. For example, one relative told us they had spoken to the manager about their concerns about agency staff used in the home last year who did not know people who lived there. They said they were satisfied with the outcome and there were "generally the same staff now". There were no written records of complaints from people or their relatives. The manager told us they had not received any written complaints.

Inadequate

# Is the service well-led?

## Our findings

The service was not well led. The service had not had a registered manager in post since the end of 2011 and since this date there had been a number of managers.

There was an incident management system in place but action taken in response to incidents had not been documented. The manager told us they had taken action in response to incidents but they only recently had training on how to use the system so had not documented this. This meant there was a risk that lessons learnt could be missed. We found some incidents recorded in people's daily notes were not recorded on the home's incident management system. For example, when a person who lived at the home had tried to harm themselves. The lack of reporting incidents meant there was a risk of appropriate preventive action not being taken. There was no analysis of incidents to look for trends and themes.

There were limited quality systems in place which meant that some areas of how the service was provided and managed were not monitored. For example, there was no monitoring of the staffing arrangements in the home and how people were supported to have drinks. The manager told us that the monitoring of fluid intake for individual people who were unable to communicate verbally had been stopped the week before our inspection as it was deemed that it was not necessary. We raised our concerns about this during the inspection as staff could not tell us about how much fluid two people that day had.

Monitoring systems in place were not always effective to identify action required to protect people from unsafe care. For example, there were systems in place to monitor weight loss for people at risk of poor nutrition. However two people who were at risk of poor nutrition had not been weighed, in accordance with the plan of care, to establish if they had lost any weight. We saw the manager reported on infections in the home and pressure sores to senior managers. The standard report did not show if there had been any deterioration in pressure sores. We were told that one person's pressure sore had deteriorated in the period of this last report. There was no system to monitor whether the correct pressure relieving equipment was in place to meet people's needs and if this happened in a timely way. We saw there had been a delay in this equipment being provided.

Feedback from people and their relatives was not always responded to in order upon to improve the service. For example, minutes of a meeting showed that a relative had raised a concern in November 2014 that there were not enough staff at lunchtimes. There was no evidence that this had been monitored and we observed that there were not enough staff to meet people's needs. One member of staff told us another relative had raised concerns about the number of staff available during the week of our inspection.

This was breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was new to the role and had only been in post since October 2014. Staff spoke positively about the manager and the changes they had implemented since they took up their post. People, relatives and staff that we spoke with told us the manager and deputy manager were making good progress in addressing the areas of improvement in the home, such as staff turnover. One person's relative told us the manager had made improvements in the home and they had confidence in them. Two members of staff told us there had been high turnover of staff in the home the previous year and how changes in the management of the home over the last few years had affected staff morale. They said the manager was addressing these areas. One member of staff told us the manager was "doing a really good job". There was evidence that the manager had an action plan to address shortfalls that had been identified in a monitoring visit by the local authority in December 2014. These included the cleanliness of the home and infection control. We saw the home was clean during our inspection but there was a strong unpleasant odour in the home. The manager and senior manager told us there were plans to replace carpets and furniture which should eradicate the odour.

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 18 HSCA (RA) Regulations 2014 Staffing<br>The provider had not taken steps to ensure that there were sufficient numbers of suitably qualified, skilled and experienced staff to meet people's needs. Regulation 18 (1). |

| Regulated activity | Regulation |
|---|---|
| | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br>The provider had not taken proper steps to ensure that the welfare and safety of each person in the delivery of care and in meeting their individual needs. Regulation 9 (3) (b) (i) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>The provider had not taken proper steps to ensure people were protected from inappropriate or unsafe care by regularly monitoring the service and identifying and managing risks. Regulation 17 (2) (a) (b). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>The provider had not ensured that people were protected against the risks of unsafe or inappropriate care and treatment from a lack of proper information for each person in relation their care. Regulation 17 (2) (c). |