Whitworth House

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Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

Whitworth House is a residential care home providing accommodation and personal care. The home accommodates up to nine people in one house. At the time of our inspection there was one person using the service. The home specialises in providing care to older people living with dementia.

People's experience of using this service and what we found

At this inspection we found the provider was still not taking adequate steps to protect people from the risk of unsafe care and treatment. Whilst staff told us they were verbally updated on people's health and welfare needs, we found care records contained risk assessments that were often unclear, inaccurate and not in line with information contained in care plans. This was particularly in regards to risks associated with dehydration, choking and skin integrity.

The registered manager still continued to fail to ensure there was adequate governance and oversight of the service, and we saw concerns raised at our last inspection and through the local authority's quality monitoring processes had not been addressed. The registered manager did not consistently adhere to the provider's policies, including in relation to incidents management. Appropriate action was not taken in response to care records audits and we saw the audits completed did not identify or address the concerns we found during this inspection.

Since our last inspection the provider had taken steps to ensure a safe environment was provided. This included in relation to monitoring hot water temperatures, ensuring call bells were accessible and in good working order, and ensuring safe fire exits.

The provider adhered to infection prevention and control procedures and safe practices were in place regarding the donning and doffing of personal protective equipment.

The registered manager was now submitting statutory notifications to the CQC about key events that occurred at the service, and displaying their latest CQC rating, as required by their registration.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection
The last rating for this service was requires improvement (Inspection November 2019, report published May 2020).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

Why we inspected
We undertook this targeted inspection to check whether appropriate action had been taken since our last

inspection in relation to the breaches of Regulation 12 (Safe care and treatment), Regulation 17 (Good governance) and Regulation 20A (display of performance assessments) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 (notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009. The overall rating for the service has not changed following this targeted inspection and remains 'Requires improvement'.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment and good 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 for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question 'requires improvement'. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Details are in our safe findings below.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question 'inadequate'. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Details are in our well-Led findings below.

Whitworth House

Detailed findings

Background to this inspection

The 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 Care Act 2014.

This was a targeted inspection to check whether the provider had taken sufficient action in relation to Regulation 12 (Safe care and treatment), Regulation 17 (Good governance) and Regulation 20A (display of performance assessments) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 (notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
This inspection was undertaken by two inspectors.

Service and service type
Whitworth House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Whitworth House is not registered to provide nursing care.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period notice of the inspection due to the risks associated with the covid-19 pandemic.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with the registered manager, the deputy manager and a care worker. We reviewed the care records for the person using the service and documentation relating to the management of the service. We undertook observations to review the safety of the environment and review compliance with infection prevention and control procedures. We spoke with one relative and obtained feedback from two representatives from the local authority.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as 'requires improvement'. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the action plan submitted following our last inspection. We will assess all of the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management
At our previous inspections in May and November 2019 we found the provider had not taken sufficient action to ensure a safe environment was provided and people were protected against the risk of receiving unsafe care and treatment. The provider was in breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□At this inspection we found the provider continued to not take adequate steps to protect people from the risk of unsafe care and treatment. Whilst staff told us they were verbally updated on people's health and welfare needs, we found care records contained risk assessments that were often unclear, inaccurate and not in line with information contained in care plans.
•□There were inconsistencies in the information provided about people's dietary needs and staff had not always consulted with medical professionals regarding changes in people's dietary requirements. This left people at risk of choking.
•□We also found sufficient action had not been taken to address the risks identified to people's health and welfare. For example, one person was identified as at risk of dehydration however, their daily fluid charts showed they often went without a drink between 5pm and 8am.
•□There were also inconsistencies in information in regards to people's skin integrity and wound management. This left people at risk of further damage to their skin.

We found the provider continued to not protect people against the risks of receiving unsafe care and treatment and remained in breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□We found improvements had been made to the safety of the environment. Call bells were regularly tested, accessible and in working order. Hot water temperatures were tested before use and found to be within a safe range. The fire doors had been alarmed so staff were made aware if someone left the service via these exits.
•□The relative we spoke with felt their family member was safe and well cared for.

Preventing and controlling infection
•□We were assured the provider was preventing visitors from catching and spreading infections.

•□We were assured the provider was meeting shielding and social distancing rules.
•□We were assured the provider was using PPE effectively and safely.
•□We were assured the provider was accessing testing for people using the service and staff.
•□We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
•□We were assured the provider's infection prevention and control policy was up to date.

Inspected but not rated

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 the last inspection this key question was rated as 'inadequate'. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the action plan submitted following our last inspection. We will assess all of the key question at the next comprehensive inspection of the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; and Continuous learning and improving care.
At our last inspections in May and November 2019 we found the provider did not have sufficient or effective procedures in place to ensure a high quality service was provided and ensure clear management and oversight of the service. The provider was in breach of Regulation 17 (Good governance) of the Health and Social Care 2008 (Regulated activities) Regulations 2014.

•There were inadequate and ineffective systems in place to monitor and improve the service.
•Adequate, correct and up to date policies and procedures were not in place for staff to follow to ensure high quality, safe care.
•The registered manager did not consistently adhere to the provider's policies, including in relation to incidents management. We found there were insufficient procedures in place to review and analyse incidents and accidents that occurred to ensure appropriate action was taken to reduce the risk of recurrence.
•Appropriate action was not taken in response to care records audits and we saw the audits completed did not identify or address the concerns we found during this inspection.
•There was a lack of oversight and management at the service. The registered manager continued to fail to ensure there was adequate governance and oversight of the service, and we saw concerns raised at our last inspection and through the local authority's quality monitoring processes had not been addressed.
•Since the service was first rated the provider had not been able to achieve a rating above 'requires improvement' for the key question 'well-led' and there was a long history of continued breaches of regulation.

The provider had failed to make sustained improvements and there was inadequate leadership to ensure a high quality service was provided. The provider remained in breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•At our last inspection the registered manager was not submitting notifications about key events that occurred at the service. Since the inspection statutory notifications have been submitted as required by their registration with the CQC. The provider was no longer in breach of Regulation 18 of the Care Quality

Commission(Registration) Regulations 2009.

• At our previous inspection the provider had not clearly displayed their CQC rating. We saw this had been rectified and the latest CQC report was clearly displayed at the service. The provider was no longer in breach of Regulation 20A of the Health and Social Care Act (Regulated activities) Regulated Activities Regulations 2014

• The registered manager did have a business continuity plan in place, including specific plans related to the covid-19 pandemic to ensure continuity of care for people using the service should there be a significant event occur at the service.

• The registered manager had introduced some regular auditing tools to review quality of care relating to infection prevention and control, and medicines management.

• There were systems in place to monitor staff's compliance with their mandatory training requirements.

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 The registered person did not ensure care and treatment was provided in a safe way for service users. Regulation 12(1).

The enforcement action we took:

We have issued a notice of decision to cancel the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not ensure effective systems or processes were established to assess, monitor and improve the quality and safety of the service. Regulation 17 (1).

The enforcement action we took:

We have issued a notice of decision to cancel the registered manager.