Croftwood Care UK Limited

Wealstone Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 17 and 18 December 2018.

Wealstone is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and we reviewed both areas during this inspection.

This is the first time this service has been inspected under the new registered provider.

The service 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.

Wealstone is a single storey residential care home which has 42 single bedrooms, seven of which have en-suite facilities. Within the 42 beds, there is a separate 11 bedded unit called Bluebells that provides care for people with mild dementia. At the time of our inspection there were 37 people living in the home.

The building was not always clean and hygienic. This visit found that there were offensive odours in some bathrooms and toilets and that areas were not clean and had not been subjected to a thorough deep- clean in order to maintain hygiene standards and minimise the spread of infection. The second day of our visit found that some remedial action had been taken but this was not sufficient to address the issue. Some maintenance issues had also been identified within the building.

The registered provider did not have effective systems in place to monitor the quality of the service. For example, not all people had a care plan in place and this had not been identified by the registered provider before we visited. This was subsequently addressed. The registered provider had also not identified before our visit that concerns from a relative had not been responded to. This had now been addressed. While the registered provider routinely sent notifications to us regarding significant incidents, they had not understood the procedure for notifying us of significant grades of pressure ulcers.

The registered provider had systems in place to ensure that people were protected from abuse. Staff were aware of who to contact if they had concerns about the care provided by the service.

Staffing levels were maintained although difficulties in recruiting domestic staff had had some impact on cleanliness standards within the building. Staff were recruited appropriately.

The management of medication was safe. Assessments were in place to ensure that people were not at risk of malnutrition, pressure ulcers or falls.

Equipment used by people were regularly checked to ensure that their use was safe.

Staff received the training they required to perform their role. Staff were also supervised appropriately.

The registered provider ensured that people's nutritional needs were met. The health needs of people were responded to appropriately.

The registered provider operated within the principles of the Mental Capacity Act 2005.

People felt cared for and that they were treated in a kind and patient manner. People had their personal information protected. People had access to advocacy service if they wished.

Care plans were person centred. Not all daily records were detailed.
We have made a recommendation in respect of daily record writing.

An activities programme was in place. Details on activities were not always advertised in line with people's communication needs.

We have made recommendation in relation to reviewing information provided to people in line with their communication needs.

A complaints procedure was in place but issues with the governance of the service meant that not all were responded to in a timely fashion.

The staff team felt supported by the registered manager. The views of people were asked for and taken into account.

The registered provider co-operated with other agencies to ensure the wellbeing of people who used the service.

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 did not live in a clean and hygienic environment.
Recruitment of new staff ensured that they were suitable to support vulnerable people.
Medication management was safe.

Is the service effective?

Good

The service was effective.
Staff received the training and supervision they needed to perform their role.
The registered provider operated within the principles of the mental capacity act 2005.
The nutritional needs of people were met.

Is the service caring?

Good

The service was caring.
People felt that the staff team valued their privacy and treated them with respect.
People's sensitive information was secured.
People had access to independent advocacy services.

Is the service responsive?

Requires Improvement

The service was not always responsive.
One concern had not been responded to in a timely manner.
Activities were provided to people who used the service.
Care plans were person-centred.

Is the service well-led?

Requires Improvement

The service was not always well led.
Audits to monitor the quality of the service provided were not always effective.
The views of people who used the service were gained through surveys and meetings.
Staff considered the registered manager to be approachable and supportive.

Wealstone Residential 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.

The inspection took place on the 17th and 18th December 2018. The first visit was unannounced and the second day announced.

The inspection team consisted of one Adult Social Care Inspector, an Expert by Experience and an Inspection Manager who was observing the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our visit, we reviewed all the information we had in relation to the service. This included notifications, comments, concerns and safeguarding information. Our visit involved looking at seven care plans, training records, policies and procedures, medication systems and various audits relating to the quality of the service. In addition to this we spoke to six people who used the service and three relatives We also spoke to the registered manager, the area manager and three members of staff. Relatives were invited to comment on the support their relations received. This was done through the provision of posters informing them of the visit and providing the contact details of CQC if they wished to subsequently talk to us. We spoke with members of the local authority commissioning team. No feedback was received from them at the time of writing this report.

As part of our inspection, we ask registered providers to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. A PIR had been returned in a timely manner by the registered provider when we asked. We used the information in the PIR to inform this inspection.

Requires Improvement

Is the service safe?

Our findings

. .People told us that they felt safe with the staff team. They told us that they were quite comfortable with them. People told us that they always received their medicines on time and were happy with the manner of the staff team while they were being supported. They told us that there was always enough staff available to help them.

Our tour of the building noted that the premises were not hygienic. An offensive odour was noted in the main hallway during the start of our visit and other offensive odours were detected in other areas of the building as we toured around.

Bathroom and toilet areas were not clean and hygienic. Taps on hand wash basins and baths were encrusted with limescale deposits. Bins were in need of emptying and baths were marked indicating that they had not been deep cleaned for some time. Boxes of disposable gloves had also been left on shelves resulting in labelling from boxes becoming imprinted on shelves. Decoration in some bathrooms was damaged and potentially could harbour germs. Clinical waste bins were left unattended and not placed in a designated trolley.

We alerted the registered manager to this and toured around the facilities showing them the issues we had identified. Our second day of the visit noted that odours were not present but many of the issues which required a deep-clean of such areas had not been attended to.

Infection control audits had been done and had suggested that the building was clean and maintained to acceptable levels of hygiene. Staff meetings had indicated that there had been difficulties in recruiting domestic staff and that all staff were responsible for hygienic standards. This team responsibility had not been successful as the deep-cleaning of bathroom and toilet areas had not been effective.

The above evidence is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did observe domestic staff and care staff using personal protective equipment (PPE) when needed. There was a sufficient supply of these items available for staff.

Cardboard boxes were stored in a corridor area. These potentially presented a fire risk. The registered manager made arrangements to move these during our visit to ensure that people were not at risk.

A staffing rota was available. This outlined the staffing numbers required to ensure that people could be appropriately supported. On the first day of the visit, one unit had one less staff available due to sickness. No additional staff could be identified to assist. Provision was made to ensure that risks to people could be mitigated. Staff told us that they considered that there were enough staff to meet the needs of people at present. Dependency tools were completed for each person so that the registered provider could monitor whether there were sufficient staff to match people's care needs. The registered provider had experienced

some difficulty in recruiting domestic staff and as a result there were not enough domestic staff to ensure that people lived in a hygienic environment.

There was a robust recruitment process in place which helped to keep people safe and ensured that people of suitable character were employed to support people. Only one person had been employed at the service since the new registered provider had taken over the running of the service. We looked at their recruitment records which showed they had been required to provide two references, one of which was from their most recent employer. New staff had also been subject to a check by the Disclosure and Barring Service (DBS). The DBS checks whether individuals have a criminal record or are barred from working with vulnerable groups of people.

The registered provider recorded accidents and incidents that had been experienced by people who used the service. These had been subjected to an analysis to determine any trends or patterns in accidents with a view to minimise future re-occurrence. These were used to enable lessons learned to be recognised and acted upon by the registered provider.

Staff demonstrated a good understanding of the types of abuse that could occur. They were clear about the systems that were in place for the reporting of any concerns and were confident that the registered manager would act upon them. Staff were also aware of how to raise concerns about poor care practice with other agencies such as CQC. The registered provider had a policy and procedure relating to safeguarding as well as information for staff on how they could raise care concerns.

The registered provider submitted a low-level safeguarding return to the local authority on a monthly basis. Low- level concerns are those events that do not meet the threshold for a more formal investigation.

Medication management was well managed. Medicines were secured appropriately in both a lockable treatment room as well as portable trolleys. Some people were prescribed controlled medicines. These are medicines which are subject to strict legal controls in respect of their storage and medication. All these had been appropriately stored and stocks recorded in the register tallied. Medication administration records (MARS) were signed appropriately and contained details of the prescribed medication, dose and other considerations to be made when being administered.

Equipment used by people who used the service such as portable hoists or assisted baths were regularly serviced in line with legal requirements. Records were maintained to reflect this. Other systems within the building such as fire- detection, fire-fighting and portable appliances were also checked on a regular basis. This meant that people were kept safe when using equipment or living in their environment.

Assessments were in place outlining the hazards faced by people from health conditions, the support they received and the wider environment. Risk assessments were in place relating to their nutrition, risk of falling and risks in developing pressure ulcers. These were all up to date and indicated clearly those people who required closer supervision in these areas. Assessments were in place outlining the risks faced by people where they required transferring from a wheelchair to their bed, for instance. Again, these outlined the level of support required and how they would be safely assisted. Personal evacuation plans were in place for each person. Known as (PEEPS), these are designed to provide staff with the information about people's needs and how to best support them in the event of an emergency evacuation. These were all up to date and were reviewed regularly.

Good

Is the service effective?

Our findings

People were happy with the food provided and told us that they had a choice in food provided. They told us that staff were good at their job and supported them well. They felt that staff knew their individual needs. People also told us that they were always referred to a doctor if they became unwell.

Prior to coming to use the service, people had their needs assessed. These covered the main needs that people had in respect of their social and medical needs as well as other issues that the registered provider needed to be aware of before a placement was offered to people. These were in place for all people but in some cases, were not signed and dated. We raised this with the registered manager who told us that this would be addressed.

Staff told us that they received training on a regular basis. They considered the training to be relevant and helpful in ensuring that they had the knowledge to support people. Training received by staff had included mandatory health and safety topics such as infection control, fire awareness and food hygiene. Other training received included safeguarding awareness, medication and the mental capacity act.

A supervision matrix was available outlining the proposed times and dates for supervision to take place. Supervision also took place in respect of staff meetings as well as checks on individual competency, for example, medication competency checks.

A structured induction process was in place. This involved initial training and a period of shadowing before staff felt able to work unsupervised and safely. Provision was available for the care certificate to be used. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of the 15 minimum standards that should be covered if you are 'new to care' and should form part of a robust induction programme.

We looked at the nutritional needs of people. Any dietary health needs were recorded in care plans as well as the likes or dislikes people had. Where health needs determine people's diets; information was also made available to kitchen staff to ensure that they were aware of these needs. We did not identify anyone who required any softer food to be served.

We observed lunch in one dining room. This was a relaxed affair with staff attentive to the needs of people. No-one required direct assistance with eating and were eat and drink independently. Drinks were available throughout the days of our visits.

Food was prepared in a well-equipped and hygienic kitchen. Kitchen staff had access to information on the health needs and preferences of people. Menus were available and indicated alternatives that could be chosen. The kitchen had received a five-star rating at the last food hygiene visit. This is the maximum rating that can be awarded. There were sufficient stocks of food within the kitchen.

Records were available in relation to people's weight. These were up to date and indicated that people who

had previously been at risk of weight loss and now reached healthy weights. This had been achieved through referral to other professionals such as dieticians

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority in this.

Staff confirmed they had received training in the mental capacity act and were able to give a summary of how capacity should be taken into account and how the best interests of people could be determined in their support. There was evidence that when applicable, authorisations seeking restrictions on people in their own best interests had been sought from the local authority and all authorisations were in date. In some cases, urgent applications were sought and granted. The registered manager maintained a list of safeguards that had been applied for or granted to ensure that expiry dates of safeguards could be monitored.

Consent was gained from people verbally. In addition to this, there was evidence that key records such as care plans had been agreed by the individual they related to.

All people who used the service was registered with a doctor. There was evidence in care plans of an ongoing commentary of appointments or medical assistance that had been sought. People also had routine appointments with opticians and chiropodists. There was evidence that ongoing involvement of physiotherapists took place to ensure that people were able to have their mobility promoted. Health needs were quickly identified, for instance, where a skin tear was identified; swift action was taken to involve the assistance of District Nurses so that the person's skin integrity could be maintained.

The registered provider had used tools linked to promoting the positive mental health of people. These ensured that the ongoing well-being of people could be monitored and interventions made when needed. Other tools were used to monitor any potential depression that people experienced. These were regularly evaluated.

We looked at how the design of the premises assisted the needs of people. The building was all on one level which assisted people with limited mobility. Signs were in place to guide people to facilities available yet these tended to be written signs as opposed to any symbols to reflect any communication needs that people had. We have raised a recommendation in respect of information later in this report.

Good

Is the service caring?

Our findings

People told us that the staff team respected them and always promoted their privacy. People told us that they were supported in a kind and patient manner.

We observed staff interacting with people in a friendly and helpful manner. We saw examples of staff knocking on bedroom doors before being invited to enter and respecting the personal accommodation of people.

Staff gave us practical examples of how they could promote the privacy and dignity of people through closing doors and curtains and covering people up while they received intimate personal care. We did see one instance when a bedroom door was left open when a person was being assisted by a member of care staff and a visiting health professional. We raised this with the registered manager who told us they would remind staff of the need to ensure privacy.

Staff were quick to respond to the wishes of individuals and provide assistance in whichever way they could. Staff spent time talking to people and offered them choice to make decisions, for example, where they wished to sit at lunch. The wider wishes of people were gained through regular resident meetings which provided evidence that people were consulted about aspects of the service. Care plans recorded the preferred names of people and these were
used in interaction with them. People had the opportunity to make decisions as to whether they wished to participate in activities. For those who did not; these wishes were respected.

Key dates in people's lives were recognised. The activities co-ordinator was able to outline what the service did to recognise people's birthdays, for example. This involved having a party for people and marking the event to make the day special for each person.

People's confidential information was kept secure at all times. Staff had received training in General Data Protection Regulations (GDPR). This relates to the protection of people's personal data. All sensitive documents were stored securely and only accessible to those who required to refer to them. Computers containing sensitive information were password- protected.

The service had received compliments about the support provided to people. Comments included "thank you for all the help and support", "thank you for all the care, compassion and love and care given" and "you are professional and caring".

Two people were receiving support from advocacy services during our visit. Advocates are independent people who are able to provide extra support or advice to people if they so wish. Information for people to access advocacy services was available.

People were able to personalise their own bedrooms. There were examples where people were able to have personal photographs and ornaments in their room. This enabled them to create a home-like atmosphere

to their own living space.

Requires Improvement

Is the service responsive?

Our findings

People told us that activities took place sometimes yet there had been a lot of activities leading up to Christmas. They told us that the activities staff were very nice and worked hard. People told us that they agreed with the care they were provided with. People knew who to complain to if they had any concerns.

The registered provider's response to concerns was not always robust. A complaints procedure was in place. This outlined the timescales for investigation and how concerns would be addressed if upheld. Comments had been received in respect of personal possessions that had gone missing. These were received in November prior to our visit. No action had been taken to follow this up or to respond to the complainant over a month later. We prompted the registered manager to respond to this and this was done to the satisfaction of the complainant by the second day of our visit. Complaints records outlined that other concerns received by the registered provider had been responded to in a timely manner.

On the first day of our visit, we identified that one person receiving respite care had not had a detailed care plan completed. This person had some important health issues yet these were briefly mentioned with no detail on how to best support this person. This meant that the person was at risk of receiving inappropriate care and that staff did not have a clear indication of how to best support this person and do it safely. This had not been picked up through the care planning audit process.

We pointed this out to the registered manager and requested that immediate action be taken to ensure that the person had a full care plan by the following day. This was addressed.

Another care plan indicated that one person was fully mobile yet this was not confirmed through our observations. We asked the registered manager to address this.

Care plans were accompanied by daily records. These were designed to give an indication of the progress people had made as well as any health or other issues that may occur. These were not always detailed and gave general statements such as "settled today" and these observations had been repeated on a few occasions.

We recommend that staff are made aware of the need to provide more personalised and detailed accounts of people's progress in daily records.

Care plans were person centred and included details of the main needs of people in respect of social needs and health needs. Care plans included personal preferences of people in respect of preferred routines, likes and dislikes. Care plans were accompanied by "This is Me" documents. These were designed to indicate the past interests, social and employment history of people so that these could be recognised by the staff team. Other information related to people's spiritual beliefs. In some cases, people stated that they followed a denomination of the Christian faith while others had expressed that they were not religious. This latter case was confirmed by the people themselves. Care plans detailed personalised ways of administering medicines to people. Other consideration was given to personal preferences when providing support. When people

required assisting with transfers; care plans outlined the need to provide reassurance to people during these times and ensure that patience was applied.

On the first day of our visit, there did not appear to any activities on offer although there was a Christmas activity at a sister care service available. It was not clear whether anyone had wished to attend this. The registered provider employed two part-time activities co-ordinators. We had detailed discussions with one co-ordinator on the second day of our visit. They were able to outline the activities that took place and how the choice of people to join in or otherwise was respected. The information included in "this is me" documents were taken into account when planning activities. For example, those who expressed spiritual beliefs were able to have access to pastoral care both within the building and thorough links to a local church. The progress of activities fed into an activities care plan with records of activities maintained. Activities of late had involved Christmas-related activities and visits from local entertainers.

We checked whether the service was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand and any communication support that they need. We looked at the information that was provided to people to ensure they had equal opportunity to access important information.

Activity boards were available but these were in written form. It was not certain whether this form of information was suitable to all people who used the service and whether it met their communication needs.

We recommend that the registered provider reviews the information it provides to people to ensure that it meets their communication needs.

We looked at how people were supported when they reached the end of their lives. While no-one was at that stage of their lives during our visit, care plans did contain an end of life section outlining future wishes and religious preferences.

Requires Improvement

Is the service well-led?

Our findings

People did not specifically comment on how well run they considered the service to be. They did express that they were happy with the care they received and were asked to attend meetings to express their views on what they wanted in respect of meals and activities.

Audits to check the quality of care provided were in place but oversight was not effective. Care plan audits were in place but these had not picked up that one care plan had not been completed. This meant that people were at risk of inappropriate care and this had not been identified by the registered provider.

Audits had been done in respect of infection control standards within the building. These had not been effective. The last audit on infection control standards had been undertaken in October 2018. This had indicated that the home was clean and tidy. Other audits prior to this had indicated that there were issues in domestic staff recruitment and that there had been an expectation that all staff 'pull together' in order to maintain standards of cleanliness. Our observations of cleanliness within the building found that many bathroom and toilet areas were not clean and this was because areas had not had a deep clean. Taps were encrusted with limescale and baths dirty, for instance. In addition to this, there did not appear to be a plan of action in respect of recruiting more domestic staff after the need for more had been identified in previous audits.

Oversight of the service had failed to identify that no action had been taken following the concerns of a relative in relation to missing personal effects. A month had elapsed between the concerns being raised and our visit. Action to address these concerns was only made after we had identified this during our visit by which time a month had elapsed.

The registered provider did not always notify us of significant events that adversely affected people who used the service. While notifications were received by us according to our records; this had not always been done. A care plan indicated that a person had developed a grade 3 pressure ulcer. A grade 3 pressure ulcer involves significant adverse damage to a person's skin integrity. It is required that we are notified of this by law. This had not been done at the time. We raised this with the registered manager who informed us that this would be done. We checked our records after our visit and found that this had still not been done.

The above evidence is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other audits had been effective. These included weekly checks on medication administration and records. As a result, it was found that no signatures, for example, had been omitted from medication records indicating that there were effective audits in place. In addition to this, accident analysis had taken place to identify trends and patterns in accidents or incidents to minimise future re-occurrence.

Staff told us that the registered manager was supportive and approachable. Staff felt that the service was well run and geared towards the needs of people who used the service. Staff meetings were held on a

regular basis to ensure that information could be passed on to staff and provide the opportunity for an exchange of ideas.

People who used the service had the opportunity to attend regular "residents' meetings". The last one was held in November 2018 and included discussions on issues such as individual accommodation, activities and meals. The views of people and their relations had been captured through annual surveys to people. Comments received had been positive about the support provided.

The registered provider worked in co-operation with other agencies. These included health professionals and nursing teams. During our visit, the registered provider was quick to respond to a health problem experienced by one person and a referral made to other medical agencies had proved to be swift and effective resulting in a positive intervention for this person.

By law, a registered provider is required to display ratings from the last inspection. This was introduced on 1 April 2015.This is to ensure that a service is transparent about its performance. This was the first inspection of the service since the registered provider changed in November 2017. The registered manager was aware of the need to display ratings following this visit.

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 The registered provider did not provide a clean and hygienic environment to control the spread of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not have effective systems in place to effectively monitor the quality of the support provided.