Care Quality Commission

Porthaven Care Homes Limited

Wiltshire Heights Care Home

Inspection report

Cottle Avenue
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Wiltshire
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Tel: 01225435600

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02 December 2015

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Ratings

Overall rating for this service	Inadequate ●
Is the service safe?	**Inadequate** ●
Is the service effective?	**Inadequate** ●

Summary of findings

Overall summary

At the comprehensive inspection of this service in August 2015 we identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued the provider with one warning notice stating that they must take action. We shared our concerns with the local authority safeguarding and commissioning teams.

This inspection was carried out to assess whether the provider had taken action to meet the warning notice we issued. This report only covers our findings in relation to the warning notice we issued and we have not changed the ratings since the inspection in August 2015. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Wiltshire Heights Care home on our website at www.cqc.org.uk.

We will carry out a further unannounced comprehensive inspection to assess whether the actions taken in relation to the warning notice have been sustained, to assess
whether action has been taken in relation to the remaining breaches, and to review the rating for the service.

At this inspection we found the provider had taken action to either fully address the issues highlighted in the warning notice or to make sufficient progress. Nursing
staff had the required core skills to be able to offer individualised care safely. There was a training programme in place to ensure competency in these core
skills and the training for the safe administration of medicines. There was a clear structure in place for clinical direction and supervision of nursing staff.

Improvements had been made to record keeping, in the level of detail care plans included and the guidance to staff on how to support people with behaviours which
may challenge. Staff were receiving training on managing behaviours in a positive way and in dementia awareness. Risk assessments clearly identified the possible triggers people may display prior to an incident, thereby enabling staff to take more preventative measures. Monitoring charts contained more information and were being more closely reviewed, however, there was still room for improvement in this area.

People had access to their call bells at all times. Care plans and risk assessments identified the location of where equipment should be placed such as sensor mats.
Staff were clear as to why equipment was used and how it should be used in order to protect people. The recording of medicines had improved, however, there
were still areas for further improvement around ensuring recording was accurate and complete. New systems were being put into place for the organisation and ordering of medicines.

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

We found action had been taken to improve safety for people who use the service. Improvements had been made to the systems to assess and manage the risks people faced.

The recording of medicines was more thorough and a change in working practices had been implemented in relation to the safe management of medicines.
We have not changed the rating for this key question from inadequate because to do so requires a full assessment of all the key lines of enquiry for this question. We will complete this assessment during our next planned comprehensive inspection.

Is the service effective?

Inadequate

We found action had been taken to improve the effectiveness of the service people receive. There were clear lines of accountability and direction for clinical staff. Nursing staff had completed the core skills required in order to offer individualised care and treatment.

We have not changed the rating for this key question from inadequate because to do so requires a full assessment of all the key lines of enquiry for this question. We will complete this assessment during our next planned comprehensive inspection.

Care Quality Commission

Wiltshire Heights 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 was 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. We undertook a focused inspection of Wiltshire Heights care home on 2 December 2015.

This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection 7 and 10 August 2015 had been made. We inspected the service against two of the five questions we ask about services: is the service safe and is the service effective. This is because
the service was not meeting legal requirements in relation to those questions and we issued a warning notice following the comprehensive inspection.

The inspection was undertaken by one inspector, a pharmacy inspector and a specialist advisor in nursing older people. Before our inspection we reviewed the information we held about the home. This included the provider's action plan, which set out the action they would take to meet the legal requirements. At the visit to the
home we spoke with ten people who live there, the manager, the deputy manager, two nurses and care staff.

Prior to the visit we spoke with two healthcare professionals who visit the home. At the visit we looked at the care records of twelve people, records in relation to
medicines management, staff recruitment and training and policies and procedures.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection of Wiltshire Heights Care Home on 7 and 10 August 2015, we found the home had not protected people against the risks of unsafe or
inappropriate care and treatment because accurate and appropriate records were not maintained. This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and
Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of the concerns, we issued a warning notice to the provider. The provider wrote to us with the
action they were going to take to address the lack of accurate and appropriate records.

At this inspection we found the provider had made sufficient progress in addressing the action plan to meet shortfalls in relation to the requirements of Regulation 12
described above. We reviewed the care records for 12 people across the dementia floor and nursing floor. There had been an improvement in the standard of record
keeping around managing behaviours which may challenge. More detailed guidance was in place for staff on how to support people to be safe and ensure all staff were
consistent in their approach. Risk assessments identified and described the triggers which people may show leading up to an incident and people were being monitored where their behaviours had changed. Staff told us they were 'more confident' in supporting people. One care worker told us there had been a reduction in incidents around behaviours which challenge and this was confirmed by the new manager. Some staff had received training in managing behaviours and dementia awareness and we saw documentary evidence that further training was taking place on 4, 15 and 16 December 2015.

Information in the risk assessments and positive behaviour support plans gave clearer instructions to staff on how they were to support people, particularly where one person's behaviour impacted on another person's. Documents were cross-referenced for staff guidance and to show a clear audit of the support given to people. Incidents were being appropriately recorded with the manager reviewing them and referring onto health professionals as required. The manager had introduced a debrief at the end of each staff shift where incidents were discussed including the need for other health professionals to be involved and an overview of how the shift went. This ensured that staff had up to date information about people's current needs and their care and treatment was being appropriately monitored and responded to.
Other care documents, such as monitoring charts had been reviewed and the overall level of detail had improved.

Monitoring charts were now more routinely in place, however, further improvement are required to ensure the charts are complete and accurate. The fluid charts did not give the total input of fluid for the day against the optimum amount; it was therefore unclear if the person had taken in the required level of fluid for that day. Fluid charts did not identify the timeframe, such as midnight to midnight and staff were recording the next day's fluid intake on the same chart, thereby making it difficult to ascertain a 24 hour total. We also looked at charts relating to repositioning, eating and drinking, elimination and catheterisation. The level of detail in the charts had improved with a focus on monitoring the person's care and welfare. For example, in one person's food and fluid charts, staff were reminded to keep the person hydrated to reduce the risk of

infections. The person had gained weight and a dietician had been involved in their care. This person had details recorded of when their next catheter change was due; however, it would be of benefit to the service to be clear about the reason the catheter is insitu which would assist staff to be aware of other factors which could impact on the person's care and welfare. The manager told us that since recently coming into post they continued to work on the completeness and quality of record keeping.

At our comprehensive inspection of Wiltshire Heights Care Home on 7 and 10 August 2015, we found the home had not protected people against the risk of using equipment which was safe to use and used in a safe way. This was a breach of Regulation 12 (1) (2) (f) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of the concerns, we issued a warning notice to the provider. The provider wrote to us with the action they were going to take to address the lack of accurate and appropriate records. At this inspection we found the provider had followed the action plan to meet shortfalls in relation to the requirements of Regulation 12 as described above. Across the nursing floor and the dementia floor we monitored the availability and use of the equipment which ten people were using. At each check, people had access to their call bells which were within easy reach. Sensor mats were placed on the floor according to the instructions given within the person's care plan and this was cross-referenced to the person's falls risk assessment. Staff were able to tell us where equipment should be placed and this was checked on a regular basis. People told us there were no issues with being able to use their call bell and one person told us why the sensor mat was in a particular position "it lets staff know that I need help and it is always here" pointing to the mat.

At our comprehensive inspection of Wiltshire Heights Care Home on 7 and 10 August 2015, we found people using the service could not be confident that their medicines were organised and administered in a safe, competent manner. Their medicines were not always available and errors in recording were made. We could not be assured people received their medicines as prescribed. This was a breach of Regulation 12 (1) (2) (g) Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of the concerns, we issued a warning notice to the provider. The provider wrote to us with the action they
were going to take to address the lack of accurate and appropriate records. At this inspection we found the provider had made sufficient progress in addressing the action plan to meet shortfalls in relation to the requirements of Regulation 12 described above. We observed people being given their medicines on the dementia floor. Staff wore a red tabard to show other people and staff they were not to be disturbed. This ensured staff administering medicines were not distracted and more able to concentrate on the task in hand. The manager had arranged for staff to attend medicines training from the home's pharmacist. Staff involved with managing medicines confirmed they had attended this training. They said this had covered the processes staff should use to ensure people's medicines were available for them as prescribed. This helped to ensure staff would be able to look after people's medicines safely.

Staff told us they still had some difficulties with the ordering of medicines if they were not in line with the regular monthly order. We saw four examples where a medicine had run out before the new monthly supply was due to start. This had resulted in two people missing a dose of one of their regular medicines. Staff were not aware the pharmacy had to make a special order for another person's liquid medicine. This meant the medicine had run out before the pharmacy could supply the repeat prescription. Staff described changes they had made to the ordering system to reduce the risk of this happening in future. We saw examples of protocols in place for the safe use of medicines prescribed to be given 'when required', for example for pain relief or to treat anxiety. However, these were not always in place and some did not have sufficient information to help staff give these medicines in a safe and consistent way. For example we saw protocols in place for two people prescribed medicines when required, if they became agitated. There was no information about how often the medicine could be given, the time interval or the maximum dose in 24

hours. The nurse told us she would ask the doctor for advice on how to complete the protocols when they visited later in the week.

Several people were prescribed creams and ointments for staff to apply. Care staff used separate records to show when they had applied these preparations. However these records were not always in place, so it was not clear whether people had their creams and ointments applied as prescribed. We saw staff giving some people their medicines in a safe and respectful way. When people were prescribed medicines to be given 'when required', for example for pain relief we heard staff ask people if they needed the medicine. Medicines were stored securely and safely. Suitable storage was used for medicines , which need additional security and records showed these were looked after safely. We saw examples of recent audits to check staff had looked after medicines safely. These showed good results but had not identified any issues with the ordering of medicines.

Inadequate

Is the service effective?

Our findings

At our comprehensive inspection of Wiltshire Heights Care Home on 7 and 10 August 2015, we found the home had failed to ensure that staff had the necessary competence, skills and experience to be able to offer safe care and treatment and meet people's needs. This was a breach of Regulation 12 (1) (2) (c), Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As a result of the concerns, we issued a warning notice to the provider. The provider wrote to us with the action they were going to take to ensure nursing and other staff had the required competence, skills and experience to provide safe care and treatment to people. At this inspection we found the provider had followed the action plan to meet shortfalls in relation to the requirements of Regulation 12 described above.

Prior to our inspection on 2 December 2015, we spoke with two healthcare professionals who visit the home as part of their role. One professional told us "things have definitely improved for the better; I understand there is a new manager in place". Another healthcare professional told us "I have not been asked to visit the nursing floor for some time. I understand there are nurses there able to do blood testing. I still visit the ground and first residential floors. Staffing there appears to be much better".
During this inspection we found the atmosphere in the home to be calm with staff going about their daily routines. People told us "it's less rushed and staff seem to have a bit more time" and "things have definitely improved and things seem more positive". The training records evidenced and nursing staff confirmed they had received training in relation to the core nursing skills, such as, catheterisation, wound care, peg feeding, taking blood, and using a syringe driver. The manager told us training would be on-going to ensure all nursing staff remained competent to carry out their role.

To enable nursing staff to attend training without impacting on staffing levels, the manager had arranged cover by using agency nursing staff. This had resulted in a
hundred percent attendance rate at training courses. This meant nursing staff were able to provide care and treatment as required by the individual without reliance on
the district nursing team to carry out certain procedures. The home had purchased a syringe driver which enabled nursing staff to carry out procedures in-house. The manager told us there was now a consistent level of nursing staff, seven in total. Upon recruitment, they had ensured that newly appointed nurses were up to date on the core skills and had a continuing professional development plan in place.

There were clear lines of accountability and clinical direction through supervision, teaching sessions, daily meetings between the manager and the newly appointed
deputy manager and the nursing team.