All About Care Limited

Wimbledon House 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?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 20 and 28 November 2018 and was unannounced.

At the last inspection we found that the Wimbledon House Residential Care Home was 'Good' in all domains. However, we found the service is now rated requires improvement.

Wimbledon House Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Wimbledon House Residential Care Home provides accommodation and support for up to 34 people living with mental health issues. At the time of inspection there were 28 people living at the service. The care home is located close to the centre of Herne Bay and a short walk to the sea front.

There was a registered manager in place. 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.

Risks to people were not always fully assessed and mitigated. Management did not learn from incidents which may have prevented harm. In addition, management failed to assess people's mental capacity when their mental and physical health fluctuated.

People were not always given medicine safely. Audits identified continued medicine administration errors, which persisted despite being raised in staff meetings and through staff notices. In addition, protocols around 'as needed' medicines (PRN), such as; cold medicine or sedatives were not specific to each person. Therefore, there was a risk that people could be given antipsychotic PRN medicine without less restrictive options considered first. We discussed this with the management who took action to rectify the concerns, by changing the medicine administration process and by seeking advice from a local pharmacist.

The quality of information recorded about people varied. Some care plans were thorough and contained information on people's likes, dislikes and preferences, whilst others were very basic local authority care plans that had not been reviewed. People had reviews to ensure that people could discuss how they wanted to be supported by staff. However, reviews did not always take place when accidents and incidents occurred or when people's needs changed.

Systems to monitor and assess the quality of the service were not always effective. Although the provider and registered manager undertook regular audits, shortfalls idenitifed were not always addressed, and areas of concern were not always recognised.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications to CQC in an appropriate and timely manner in line with CQC requirements.

People felt safe living at Wimbledon House Residential Care Home. People told us that they would feel confident raising concerns and complaints with the managers. They also felt confident raising issues in resident's meetings and when talking to their keyworker. People told us that staff cared for them and respected their views and beliefs. Some people went to church and church services took place at the service which people attended. Staff supported people to take part in activities that interested them. However, some people felt activities at Wimbledon House Residential Care Home could be improved. This had been raised to management and they had recently hired an activities coordinator.

Staff knew what to do if they witnessed or suspected abuse and there was a safeguarding and whistleblowing policy that staff were aware of. Staff also attended annual safeguarding training. Environmental risks were assessed, and staff knew what action to take in the event of an emergency. There were enough staff to support people and a robust recruitment process ensured that staff were safe to work alone with people. New members of staff underwent a thorough induction programme and existing staff had regular face to face training that they found helpful to their roles. However, training was not always effective as shortfalls continued to be identified.

Staff were aware of people's mental health needs and physical needs, as well as their hydration and dietary requirements. People had access to a range of different meals and alternatives were always offered. The chef talked to people about options and those with specialist dietary requirements were catered for. Staff worked closely with professionals to enable people to live as healthy life as possible. Staff knew when people were unwell, and we saw that appropriate referrals to health professionals had been made. People were supported to attend medical appointments and a weekly GP clinic was held at the premises. When people visited other services, information about the person was taken to promote consistency in care.

The premises met people's needs. Communal areas were decorated in a homely way and each person could decide how their room was decorated. There were different areas for people to socialise or relax in and environmental changes were made to accommodate people when their physical needs changed.

Staff respected people's privacy and dignity and understood principles of consent. Staff attended mental capacity and deprivation of liberty training, as well as equality and diversity. People were encouraged to be as independent as possible. We saw people were offered choices and their decisions were respected.

Staff felt comfortable raising concerns in supervisions, appraisals and in staff meetings and felt supported by the management. Each year the management asked for feedback from people, staff, relatives and health professionals. Comments were collected and analysed by the provider to develop the quality of the service provided to people.

The registered manager attended local forums for registered managers, to learn about the latest and best practice. This information was passed to staff through staff meetings and notices. Management liaised appropriately with local agencies, such as; professionals and the local authority.

During this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. You can see what action we told the provider to take at the back of the full version of this report.

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.

Risks to people were not always identified and mitigated.

Medicines were not always managed safely.

Lessons were not always learnt from incidents and accidents.

There were enough staff to support people and staff were recruited safely. People were protected from the risk of abuse.

People were protected from the spread of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff knew how to seek consent from people but were not always knowledgeable about the Mental Capacity Act 2005.

Staff received training and support. Not all training was effective and improvements were needed.

People had access to regular drinks and nutritious meals.

Staff worked closely with professionals and made appropriate referrals when people were unwell.

The premises met the needs of people.

Is the service caring?

Good

The service was caring.

People felt that staff cared about them.

Staff respected people's dignity and encouraged people to live independent lives.

People, their relatives and advocates were involved in decisions about their care and support.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always reflect people's health and social needs.

People felt confident that they could raise concerns and complaints and that they would be investigated appropriately.

People's end of life wishes were recorded and respected.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider failed to effectively identify, monitor and mitigate risks to people.

Checks and audits were ineffective. The provider had not picked up shortfalls identified on inspection. Other audits identified shortfalls but action taken was insufficient as shortfalls continued.

The management and staff shared the same vision for the service and a kind and compassionate culture was clear to see. People praised the registered manager and provider.

People, relatives, staff and health professionals were asked for their feedback which was collected and analysed by the provider.

The managers worked closely with professionals and agencies and attended local best practice forums.

Wimbledon House 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.

This inspection took place on 20 and 28 November 2018 and was unannounced.

The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a separate investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of community safety. This inspection examined those risks.

Before visiting the service, we looked at previous inspection reports and information sent to the Care Quality Commission (CQC) through notifications. Notifications are information we receive when a significant event happens, like a death or a serious injury.

We also looked at information sent to us by the manager through the Provider Information Return (PIR). The PIR contains information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used this information to plan our inspection.

We looked at a variety of different sources of information relating to people, including five care and support

plans and risk assessments. In addition, we looked at staff rotas, training records, recruitment files, medicine administration records, complaints and incident logs. We asked the deputy manager to send us some documentation after the inspection. These were received.

We spoke with 15 people and observed interaction between people and staff. We also spoke with two members of staff and the registered and deputy manager. We sought feedback from a local authority commissioner and pharmacist. Feedback received has been included in the report.

Requires Improvement

Is the service safe?

Our findings

People were supported to live as independent lives as possible. People were able to go out and about as they wished, and staff discussed the associated risks with people which were accepted. However, not all risks to people had been assessed or risk assessments updated when changes occurred in people's physical and mental health conditions.

Staff identified some risks to people and took action to mitigate them. For example, there were risk assessments and guidance for staff on how to manage a person's diabetes and another who was at risk of falls. However, risk assessments were not always kept up-to-date so did not reflect the risks to people at that time. One risk assessment stated that a person needed a fluid chart due to their risk of infection, however the fluid chart had not been completed since the 17 October 2018 and entries prior to this date were incomplete.

Some people were more independent than others and liked to spend time in the local community. However, risk assessments were not in place to ensure that people were as safe as possible when alone in the community if and when their mental health declined. When people's mental health declined, and their capacity to make decisions was in question it was identified by staff, but risk assessments and capacity assessments were not completed or updated to establish whether the person was safe to be alone in the community. Following the inspection, risk assessments were put in place for people who travelled alone in the community.

Accidents and incidents were recorded by staff and investigated by management. Staff made referrals to relevant professionals, if they noticed patterns, such as; people falling more or an increase in behaviours that challenged others. However, lessons were not always learnt when incidents occurred. For example, when people whose capacity was in question went missing, staff had not done all that is reasonably practicable to reduce risk of the same incident reoccurring. In the last 12 months, a number of people had been reported missing to the police. On the days between inspection, one person had been missing overnight. Due to a decline in their mental health, this same person was under close observation at home at the time of going missing. However, the person's capacity and risks to the person travelling alone in the community had not been considered and mitigated and the person had gone missing twice since the inspection. The failure to ensure risks to people were assessed and mitigated is a breach of Regulation 12 (Safe care and treatment) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to the medicines they required, and staff organised medicine reviews to make sure the medicine people were taking was appropriate. However, medicines were not always managed and recorded safely. Two medicine audits carried out by a staff member between 1 October and 10 October 2018 found repeated medicine errors, including failure to sign to say that medicine had been administered. We saw that medicine errors had been discussed in residents' meetings and notices had been sent to staff. However, errors continued and a pharmacist audit on 29 November 2018 found that medicine balances did not tally. We discussed medicine errors with the deputy and registered manager and they told us that staff were sometimes distracted when giving people medicine. On the second day they had updated the policy and

implemented a new procedure for giving people medicines. This involved two members of staff, one to oversee and evidence that medicines had been administered and signed off by the member of staff.

People were given 'as needed' (PRN) medicines, which included medicines ranging from cold medicine to medicine prescribed to people for their mental health condition. However, on inspection we saw that there was a generic PRN protocol but there was no guidance for each person using a PRN, describing signs, symptoms and triggers. We discussed this with the deputy manager who agreed it was an area for improvement. After the inspection we were sent an example PRN protocol for a person.

Medicines records were not completed accurately and there was a risk that behavioural PRN medicines were not always used appropriately. This is a breach of Regulation 12 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place to protect people from abuse. Staff could identify signs of abuse and knew what to do if they suspected or witnessed abuse. They told us that they would report their concerns to senior colleagues and management or follow whistleblowing policies.

There were enough staff to support people. Staff rotas were made using a dependency tool to assess people's needs and how many staff were required to meet their needs. Staff were recruited safely. The manager conducted checks prior to staff starting their jobs to ensure that new staff were safe to work with people. At times of staff sickness or emergency, a duty system ensured that people were provided with the support they needed. On occasions, agency staff were used. Before using agency staff, checks were carried out centrally by the provider's main office and agency staff had to conduct an induction session before working at the service. A person told us; " I love the place, I like the staff. There is enough staff to support me."

People were protected from infection. Staff had infection control and hazardous substances training and knew how to protect people from the spread of infection. Cleaning staff had cleaning schedules, which were checked by management. When serving food or supporting people with personal care we saw staff using protective equipment such as aprons and gloves.

Requires Improvement

Is the service effective?

Our findings

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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

Staff had knowledge of the MCA and what it meant for people, however management did not conduct mental capacity assessments, despite having said in people's care plans that their mental capacity fluctuated due to relapses in their mental health. When people's mental health declined, staff liaised with the mental health team and local authority care coordinators. Yet they did not carry out their own mental capacity assessments to ensure that people were provided with the right level of care and support for their needs. There was a person living at the service whose mental capacity was in question, however no capacity assessments had taken place. Therefore, if people needed to be deprived of their liberty or needed support in making decisions about what was in their best interest, this could be delayed until the person had been seen by the care coordinator and/or psychiatrist. This is a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The deputy manager told us that they would add a MCA section to the computerised care plans, so that they could add mental capacity assessments. On the second day of inspection, we saw that this had been added. However, the deputy manager had not yet completed mental capacity training but was booked on upcoming training.

Staff received face to face training regularly and they described the training as helpful and informative. People felt staff had enough training to support them. New members of staff went through a thorough induction period, shadowing of senior members of staff and competency assessments to learn how to support people. However, continued medicine administration errors demonstrated that the training and competency assessments were not always effective. This was an area for improvement.

Staff felt supported by management. Supervisions were held regularly, as well as annual appraisals. Staff told us that they found supervisions helpful as they were able to discuss training, development opportunities and share concerns and ideas with the registered manager.

Staff worked closely with health professionals to promote and support a healthy lifestyle. When people were unwell or unhappy, staff noticed and made the appropriate referrals to professionals. For example, they

noticed that a person had lost weight, so they made a referral to the dietician and monitored their nutritional and fluid intake. A GP held a weekly clinic at the service, and we heard people and staff talking about how they felt and whether they would like to be added to the list to talk to the doctor.

When people were visiting health services or were admitted to hospital, staff took a summary of people's care needs as well as their medicine records. The registered manager had also been to a forum where the 'red bag scheme' that the service had signed up for were discussed. These bags would go with people to medical appointments and when admitted to hospital and held information about them, so that a consistent level of care could be given to people across different services.

People had access to a choice of nutritious meals and hot and cold drinks were available throughout the day. People told us that they enjoyed the food at Wimbledon House Residential Care Home. On the inspection, we saw people had a choice of gammon, roast potatoes and vegetables, sausage and mash or a vegetarian option. Each smelt and looked appetising and people told us that they were enjoying their meals. One person told us that they were hoping to move from a vegetarian to a vegan diet, and the chef was supporting them with this by researching and cooking vegan dishes for them.

The premises met the needs of people living at Wimbledon House Residential Care Home. It was clean, tidy and well maintained by the maintenance team. There were different areas around the premises for people to spend their time quietly or to socialise. A person told us that they had struggled with the stairs following a fall, so the manager moved their bedroom downstairs to make it easier for them. The premises were decorated in a homely way, and people could decide how they wanted their bedrooms decorated. We saw people had displayed their pictures and personal belongings. One person told us; "I have a TV in my room, lots of pictures of my family. I have got everything I need in my room."

Good

Is the service caring?

Our findings

The atmosphere at Wimbledon was respectful and compassionate. It was clear when observing interactions between people and staff that staff cared for people. People smiled and laughed with staff and went to them for comfort and reassurance. Staff knew people well and talked about them with fondness. Staff took time to sit and listen to people. One person told us; "The staff are so kind, I love living here". Another commented "I think staff care about me, if there is anything wrong they help you".

Most people living at Wimbledon House were able to communicate their wishes and preferences. One person did not communicate verbally, but staff knew what the person wanted by the way they moved their hands and their body language. Staff organised advocates for people who did not have family. Advocates support people to express their views and wishes and help them to stand up for their rights.

People were supported by staff with their individual interests and hobbies. People enjoyed going to a local pantomime yearly. Staff also performed their very own Christmas pantomime each year which people told us they enjoyed. People attended resident's meetings where they would discuss food options, activities and any concerns or issues. Venues for the upcoming Christmas meal had been discussed and the chef had been to a meeting to discuss people's preferences for the new winter menu. People had also discussed activities they would like to try, some mentioned that they would like to try crazy golf, and this had been organised by the managers.

People's family or friends were able to visit them at any time and people were supported to speak to their families regularly. Staff had recently set up a video calling computer application, so people could see their loved ones who they could not otherwise see regularly.

Staff were respectful of people and their beliefs and preferences. People attended different churches as and when they wanted to. In addition, weekly services were carried out by a member of staff which people regularly attended. People were able to do what they wanted, when they wanted, and one person told us; "I can go to the lounge, or I can go to my room, so I can have some private time, it depends on how I feel". Other people visited the local shops and cafes.

People were encouraged to be as independent as possible. A member of staff told us that they promote people's independence by; "Assisting them with what they need but encouraging them to do what they can. Like helping someone to get ready for the day, I say 'there's the hot water and the flannel, I'll leave you to do what you can do'. I'll leave the room, so they have some privacy then pop back and ask if they need any help".

People told us that their dignity and privacy were respected; staff appreciated peoples private time and knocked before entering people's rooms. Staff had equality and diversity training and people were treated with equal respect and warmth. Information relating to people were kept confidential and staff understood their responsibilities to do so.

Requires Improvement

Is the service responsive?

Our findings

People were supported to live independent and active lives. People could choose what they wanted to do and when they wanted to do it, and their decisions were supported and respected by staff. Staff spent time getting to know people, their likes, dislikes and interests to ensure the service provided to people was person-centred.

People's care plans did not always describe how they wanted to receive their care and support. Some care plans were very basic and contained little more than the local authorities care plan. These temporary local authority care plans had not been updated since people had moved from previous placements to the service, despite significant extensions to their initial respite period, incidents of importance and changes to their mental wellbeing. Nevertheless, because staff knew people and were receptive to changes in their needs, people received responsive care. Care plans were an area for improvement that was being addressed by the deputy and registered manager and they were in the process of updating and computerising care plans.

People were supported to participate in activities of their choice. Staff had supported one person to go on a trip to Chatham dockyards: They used to be in the navy and was passionate about boats. They went around the museum and on former navy boat and we were told how much the person enjoyed the trip. Another person wanted to write their life history, so a member of staff was helping them to do so by writing down what the person dictated to them to make their very own book. However, people still felt that the activities could be improved within Wimbledon House. As a result, an activities coordinator had recently been recruited but had not yet started. We met this new member of staff and they had lots of plans for improving the quality of the activities taking place at Wimbledon House, including; visits from therapy animal and parties.

Each person had their own keyworker. A keyworker is a member of staff responsible for the quality of care provided to their allocated person. People had regular meetings with their keyworkers, where they would discuss their care and support and whether any changes could be made to improve how they were supported. People told us; "We meet with staff to discuss things, I find it helpful."

People told us that they would feel confident talking to staff, the deputy or registered manager if they had any concerns. We saw that complaints were investigated thoroughly by management, action was taken, and apology letters were sent when appropriate.

People had been consulted about their end of life wishes, these were recorded and respected. For example, one person with a terminal illness had a bucket list of things they wanted to achieve before they died. One of those goals was to have a flight in a helicopter. Staff helped to achieve this by organising the flight, which was a cause of great happiness for the person. Staff also worked with the person to plan their funeral, and when the person passed away, they had exactly the funeral that they wanted.

Requires Improvement

Is the service well-led?

Our findings

The provider and registered manager had systems in place to monitor the quality provided to people, but these were not always effective. Such checks had not identified shortfalls found on inspection, including key issues around care plans, risks and staff competencies. Other shortfalls had been identified but had not been resolved, such as; repeated medicine errors and the lack of personalised guidance for each person using 'as needed' medicine. Some checks were delegated to members of staff, for example; medicine charts, weight charts and cleaning schedules. Following the identification of repeated shortfalls, a designated staff member responsible for completing medicine audits increased the audit from monthly to weekly. Yet, when this member of staff was off on leave, no other members of staff completed these checks and the registered persons were unaware it had not been completed for four weeks.

The registered provider visited the service, where they walked around the premise talking to people and staff. They did not undertake any formal checks or audits on these visits. The registered person's had failed to ensure a robust approach to monitoring and driving improvements to the quality and safety of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of the provider's vision and values and staff demonstrated their understanding when interacting with people. The provider stated on their website that 'Everyone in our care has a right to a lifestyle, which maintains their personal independence, safeguards their privacy, offers genuine choice and meets their social, cultural and individual needs'. These values were embraced by staff; people were encouraged and empowered to be as independent as possible. There was an open and transparent relationship between staff, people and management; staff felt able to discuss ideas and concerns informally and through supervisions and staff meetings.

Staff, people and relatives praised the leadership at the service, comments included; "I get on well very with [registered manager]", "[the registered manager] is lovely, [the deputy] is very good too." An 'open door' policy was used for people and staff and we saw it in operation on inspection, one person told us; "It's easy to talk to the manager." Staff told us that they felt supported and valued by the registered manager. Team meetings were held so that staff could share best practice, ideas for improvement and any concerns they had.

There was a registered manager in post. 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. The registered manager had recently attended a local best practice forum to discuss a new way of sharing information between services when people were admitted to hospital. This scheme had since been implemented. The registered manager also had a good relationship with local professionals, such as; GP and community nurses. We saw that when a person developed pressure areas, the registered manager liaised closely with the appropriate professionals.

Staff, people, relatives and health professionals were asked for their feedback through yearly questionnaires. A person told us; "They are very caring. [The registered manager] is lovely, they asked me for my views recently. [The provider] comes regularly. If you are unhappy they make sure you get whatever you want." Information from the surveys was collected and analysed by the provider to monitor and maintain the quality of the service provided to people. The local community were also invited to attend an annual summer fete, along with people's friends and families. The deputy and registered manager told us that this was always a success and enabled people to build relationships with their neighbours.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications to CQC in an appropriate and timely manner in line with CQC requirements.

People's private information was stored safely. The rating for the service was displayed in the hallway for people to see and was also displayed on the provider's website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks had not been properly assessed or mitigated. Medicines were not safely managed. The Mental Capacity Act 2015 was not being complied with.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was insufficient oversight of the quality and safety of the service.