Careline Lifestyles (UK) Ltd

Wilkinson Park

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service: Wilkinson park is a residential care home which can provide personal care for up to 21 people, including people with learning disabilities. Accommodation is provided over two floors and there are three separate units where people live more independently. There were 14 people using the service at the time of our inspection.

People's experience of using this service: People were supported by staff they liked and knew well, however, risks relating to people using the service were not effectively monitored, mitigated or recorded. There was insufficient attention to the monitoring of supervision arrangements for people who required additional support to keep them and others safe.

An effective system to demonstrate that sufficient staff were deployed to meet people's needs was not fully in place. Some staff were regularly working excessively long hours. Some people were bored and there was a lack of evidence that people's social and occupational needs were being met.

Electronic records were not maintained to a satisfactory standard. There were gaps in record keeping and key information about people's care including risks was not always clearly recorded. Following the inspection, the provider wrote to us and stated, "Since the inspection, care plans have all been reviewed and been rewritten where necessary and will be reviewed monthly."

The home was not satisfactorily clean. There were no domestic staff employed at the time of the inspection meaning care staff were also responsible for cleaning. Environmental risks we found had not been identified by the provider's own health and safety audit. This placed people at risk of harm. Following our inspection, the provider wrote to us and said that external cleaning contractors had been recruited to deep clean the service and a refurbishment plan was being implemented.

People were supported day to day to have maximum choice and control of their lives by staff however, they were not always supported in the least restrictive way possible due to issues with staff deployment and access to transport. Where formal restrictions had been placed on people, these were not always clearly recorded. Following our inspection, the provider told us they had purchased a second vehicle to help improve people's access to transport.

Safe staff recruitment procedures were followed, recruitment was ongoing. Medicines were managed safely.

Staff received regular training. There were some gaps in supervision and appraisals however plans had already begun to address these when we started our inspection. Appraisal and supervision records were detailed.

The service was a large home, bigger than most domestic style properties. It was registered for the support of up to 21 people. 14 people were using the service. This is larger than current best practice guidance

although the service was registered before the registering the right support guidance was in place. However, the size of the service having a negative impact on people was mitigated in part by the building design which meant some people could live in smaller domestic style premises on the property.

The principles and values of Registering the Right Support other best practice guidance ensure people with a learning disability and or autism who use a service can live as full a life as possible and achieve the best outcomes that include control, choice and independence. At this inspection the provider had not always consistently applied them.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons. Whilst the provider sought to promote choice and independence, we found access to and choices of activities were restricted through issues with staff deployment and transport availability.

The environment needed updating and refurbishment. We requested a plan and timescales for upgrading the premises and facilities but had not received this at the time of the report. The provider contacted us to say they would share these plans with us our following our inspection. The grounds were very well maintained.

People were supported with eating and drinking. The provider told us there were plans to replace the kitchen as part of wider refurbishment plans, with the addition of a new kitchen and dining facilities for people to use.

Staff knew people well and showed care and concern for their welfare. People liked staff and knew how to raise any concerns about their care.

A new manager had been appointed but had not yet registered with the Care Quality Commission (CQC) and resigned from their position during our inspection. Communication was not always effective in the service and records were disorganised. Important information could not always be located.

Audits and checks were carried out on the quality and safety of the service. These had not always identified all the issues we found and where they had, timely action had not been taken.

Several incidents had not been notified to CQC in line with legal requirements. We are dealing with this outside the inspection process.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection: Good (published October 2017).

Why we inspected: This inspection was prompted by information of concern.
We have identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 in relation to safe care and treatment, person centred care and good governance. Please see the action we have told the provider to take at the end of this report.

Since the last inspection we recognised that the provider had failed to comply with the condition to have a registered manager in post and had failed to notify CQC of all incidents in line with legal requirements. This was a breach of regulation. 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.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Wilkinson Park

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. This inspection was planned to check 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.

The inspection was prompted by information of concern.

Inspection team: The inspection team consisted of two inspectors.

Service and service type: Wilkinson Park 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.

The service did not have a registered manager in post. There has been no registered manager in the service since 1 August 2017. We are dealing with this outside the inspection process.

Notice of inspection: The first day of this inspection was unannounced. Further site visits were announced to ensure a provider representative could be present.

What we did before the inspection: We used information we held about the service and contacted the local authority contracts and safeguarding teams when planning our 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 eight people, a manager, head of care delivery, team leader, a quality officer, health and safety officer, a chef, three care staff, three senior care staff and two visiting professionals. We spoke with the nominated individual by telephone during our inspection and by email following our

inspection. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We read five care plans, three staff recruitment files and a variety of records relating to the quality and safety of the service.

After the inspection: We continued to seek clarification from the provider to corroborate the evidence we found. We looked at training data and requested confirmation of management arrangements, plans to address environmental issues and sought information relating to transport. We spoke with two professionals who regularly visited the service. We also contacted another professional by email to request their feedback about the home. We continued to liaise with the local authority safeguarding team after the inspection who were visiting the service regularly.

Requires Improvement

Is the service safe?

Our findings

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

Requires improvement: This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
- Staff were able to describe individual risks relating to people, however records relating to safety, monitoring and risk management were disorganised and difficult to locate.
- Electronic risk assessments lacked detail and had not been kept under review. Electronic care plans in place to mitigate risks had not been kept under regular review.

The lack of effective recording and monitoring of risk exposed people to the risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Following our inspection, the provider wrote to us and stated, "All risk assessments regarding behavioural risks have been reviewed to ensure that they are person centred and relate to the risks posed by people."

- We identified shortfalls in the management of risk. Three people had obtained equipment which placed them/others at risk of harm.
- Items which should have been inaccessible to some people were left in an unlocked cupboard in an area used by people.
- Individual risk assessments were not in place relating to hot water temperatures in kitchen areas used by people. Following our inspection, the provider told us that this had been addressed.
- We found there was no fire detection alarm in a linen cupboard which had a wall light with exposed bulb. A temporary smoke alarm was put in place following our inspection until a permanent alarm could be installed.

Systems and processes to safeguard people from the risk of abuse
- There was insufficient attention to the monitoring of supervision arrangements for people who required additional support to keep them and others safe.
- Information relating to the safeguarding of vulnerable people was not always reported or documented in a timely manner.
- Due to a number of concerns of a safeguarding nature, the local authority had placed the home into 'organisational safeguarding.' This meant the local authority was monitoring the home and supporting them to ensure the correct procedures were in place to keep people safe. The provider was cooperating fully with this."

Preventing and controlling infection
- Some areas of the home were not clean. Two bathrooms and a toilet were not cleaned to a standard

which would help prevent the spread of infection and promote a pleasant environment for people. Exposed wood on the bath panels and furniture in these two bathrooms posed an infection control risk. The laundry was situated outside. The laundry floor could not be easily cleaned, cupboards had no doors and there were cobwebs and debris hanging from the ceiling and windows. Some people were independent in cleaning their own rooms so standards of cleanliness were a personal affair. Other people required support however, and this had not always been provided. There was thick dust in one person's room.
● There were no domestic staff employed as the provider explained they had difficulty recruiting. This had been an issue previously in the service and agency domestic staff had been used but this had stopped.

Due to poor safety monitoring of the environment and individual risks, people were exposed to the risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Following our inspection, the provider wrote to us and stated, "External cleaning contractors have been recruited to deep clean the service and the refurbishment plan is being implemented."

● Gas, electrical and water safety checks continued to be routinely carried out.

Staffing and recruitment
● An effective system to demonstrate that sufficient staff were deployed to meet people's needs was not fully in place. Staff agreed it was hard to meet the needs of all people within the current staffing levels.
● Recruitment was ongoing. Shortfalls in staffing were covered by existing staff working excessive hours, exceeding 60 hours per week on a regular basis.
● Staff told us they did not always feel they had a choice about working extra shifts. One staff member said, "Staffing is the main concern. We are all over worked."
● As there were no domestic staff employed at the time of the inspection, care staff were responsible for the cleaning of the home in addition to caring duties. Following our inspection, the provider informed us that staffing hours were calculated to incorporate time for staff to undertake some domestic tasks when not undertaking their care duties.
● People were funded for designated 1:1 support hours with staff for specific activities. One person told us they did not always receive their 1:1 hours. Records did not always evidence the 1:1 support which was provided. This was confirmed by a visiting professional.

The failure to have an effective system in place which demonstrated that sufficient staff were deployed to proactively meet the needs of people was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Learning lessons when things go wrong
● A record of accidents and incidents was held and analysed by the head of care delivery on a regular basis.
● The general quality of reporting and recording information in the home compromised this process. The head of care delivery told us they had amended the system to ensure staff could not complete the incident records without recording specific information in mandatory fields.

Using medicines safely
● Safe systems continued to be in place for the management of medicines. There was an issue with the electronic system due to an IT failure. Steps were taken, however, to ensure people received their medicines safely. Medicine errors were recorded appropriately with a record of action taken.
● Staff received training in the administration of medicines and had their competency checked.

● An NHS medicines technician visited the service during our inspection. They advised the manager to change the day of audits to ensure should any issues with stock be identified, there would be time to rectify this. This was done immediately.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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.

- The provider sought to work within the principles of the MCA, staff offered people choices throughout the inspection, and there were some detailed records relating to specific decisions for some people.
- We were unable to locate clear information about restrictions placed on people including conditions of discharge under the Mental Health Act at the time of the inspection. The provider submitted this information following the inspection and informed us that this had been available in people's paper records. We considered however, that staff were not aware of this at the time of the inspection, and this information had not been easy to locate."
- MCA documentation in the new electronic record system was incomplete and had not always been kept under review. One person's electronic care plan contained inaccurate information about their legal status.
- One professional informed us that Information requested by the Court of Protection to be sent to them was insufficiently detailed and not provided to them in a timely manner.

Electronic records relating to people's mental capacity and legal status were not well maintained. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- Pre-admission assessments were undertaken before people moved into the home.
- The pre-admission information we checked for one person who had been admitted as an emergency placement was detailed, however had not been undertaken involving staff from Wilkinson Park who knew

other people well. This admission had not gone well. The head of care delivery advised they were looking at how to strengthen the process to ensure people were well matched with the service moving forward.
● People's assessed needs and choices were not always kept under review. Following our inspection, the provider wrote to us and stated, "Since the inspection, care plans have all been reviewed and been rewritten where necessary and will be reviewed monthly."

Staff support: induction, training, skills and experience
● Staff received an induction at head office and received regular training deemed mandatory by the provider.
● Training provided was relevant to people's specific health conditions.
● There were some gaps in supervision and appraisals but plans had already commenced to address this when we started our inspection. The appraisal and supervision records we read were detailed and relevant to the individual staff member.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported with eating and drinking and people had been encouraged to consider eating healthily.
● Some people were supported to cook their own meals, and the cook was aware of people's preferences and special diets.
● The food standards agency rating for the kitchen was three which meant hygiene standards were generally satisfactory and structural work had been recommended at their last two inspections to improve this. The provider advised us following the inspection there were plans for kitchen refurbishment which would address this.

Staff working with other agencies to provide consistent, effective, timely care
● People were supported to attend medical appointments and people had access to a variety of health professionals.
● Two visiting professionals told us communication could be improved between them and the home and said they had not always received information they requested or required in a timely manner.

Adapting service, design, decoration to meet people's needs
● People's rooms were personalised. The décor and furniture in some areas of the home was tired and in need of updating. The provider told us after the inspection they had plans for improving the building which they planned to share with us.
● The grounds were extremely well maintained and people told us this was important to them and they were very happy with the access they had to the gardens.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

Requires improvement: People did not always feel well-supported, cared for or treated with dignity and respect.

Due to the concerns we identified during our inspection we could not be assured people were receiving consistently kind and compassionate care. We have taken this into account when rating this key question.

Supporting people to express their views and be involved in making decisions about their care
- Some people told us they were encouraged to express their views and make decisions about their care but said they did not always feel their views were acted upon.
- Care records did not always evidence people had been included in decisions about their care, or been offered the opportunity and declined.
- Staff included people in day to day decisions during our inspection about how and where they wanted to spend their time.

Ensuring people are well treated and supported; respecting equality and diversity
- Most people told us they liked staff. One person told us, "Staff are all nice and pleasant they'll bend over backwards to help you." Another said, "Staff are okay, I like the staff they are all good."
- There were numerous examples of caring interactions between people. People who became upset were comforted and reassured by staff.
- Staff told us and we could see they were dedicated and committed to the home and wanted to do their very best for people.

Respecting and promoting people's privacy, dignity and independence
- People's privacy was protected by staff however the issues we identified in relation to cleanliness compromised the dignity of some people.
- Staff made sure people gave us permission to look at their private accommodation and asked people to show us around.
- Some people lived semi independently where they were encouraged to do as much for themselves as possible with an agreed level of staff support and supervision.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires improvement: People's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Electronic care plans were in place which varied in quality and detail. There were some plans which contained good information, but several electronic care plans lacked the detail required to ensure they were person centred.
- There were multiple gaps in electronic records relating to people's individual care needs and preferences.
- There was insufficient evidence people were involved in the care planning process. Person centred care plans had not been reviewed monthly. Some had not been reviewed for several months.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Some people told us they were happy with the activities they took part in. Several other people told us a lack of transport meant their choices and opportunities to take part in activities was limited.
- There was one vehicle available for use by people as the other had been involved in an accident. One car was available for 13 people and priority was given to transporting people to medical appointments which further restricted the availability of the vehicle.
- The location was very rural and isolated with public transport running a limited service. People had no access to public transport four days a week, and when they did, they complained they had to visit the same places for shopping.
- Several people were allocated one to one time with staff. One person told us that this did not always happen. Records did not fully evidence people's one to one time Staff told us people sometimes refused their one to one time, but this was not always recorded.
- Records of activities offered to people were poor.
- A social worker expressed concerns about the quality of activities recorded such as watching TV or spending time in room as these were not examples of meaningful occupation.

Access to meaningful occupation and choice were restricted due to issues with staff deployment and a lack of transport, and people were not always involved in the care planning process or reviews of their care. Care plans were not always person-centred. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Following our inspection, the provider wrote to us and stated, "Since the Inspection, care plans have all been reviewed and been rewritten where necessary and will be reviewed monthly." They also stated that a second vehicle had been purchased and was in place to improve people's access to transport.

Meeting people's communication needs

From August 2016 onwards all organisations that provide adult social care are legally required to follow the Accessible Information Standard (AIS). The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. The standard applies to people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Accessible information was available to people as required.
- People used communication techniques with people they knew they responded to.
- Interpreters were booked when required.

Improving care quality in response to complaints or concerns

- People were aware of how to make a complaint. An easy read complaints procedure was available on request.
- A complaints procedure and record was in place.

End of life care and support

- End of life care was not provided in the home but people could share their wishes for the future if they wished to do so.
- One person who had spent a long time in the service had died in hospital shortly before our inspection, which had affected people and staff. A mural had been created with photographs to celebrate the person's life and encourage people to talk about their feelings.

Inadequate

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.

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The governance of the service was ineffective. Audits had been carried out but they had not always identified the concerns we found during our inspection. Where they had, findings were not acted upon in a timely manner which put people at risk.
- Although some records contained good information, many were disorganised, lacked detail, and had not always been kept under review. Specific information about risks relating to people were not all clearly recorded. These were updated as a matter of urgency during our inspection.
- The provider was moving to a new electronic system. Staff lacked confidence in the new system and internet access was not always available.
- The service did not have a registered manager. A new manager was in post at the beginning of the inspection but had left by the end of our inspection. There had been no registered manager in post since August 2017. We are dealing with this outside the inspection process.
- There was no detailed role specific induction for new managers. The provider told us this was going to be developed.
- An effective system was not in place to ensure all required notifications were submitted to CQC in line with legal requirements.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Staff told us the lack of permanent manager had impacted upon morale and the smooth running of the service. Staff acknowledged the support provided by the head of care delivery but described the overall support from the provider as poor. One staff member said, "We needed you to come in and give us a kick because head office don't. We feel forgotten. Apart from [name of senior manager] I feel they don't know us; head office should be more visible."
- There was no evidence any surveys had been completed in the previous 12 months to obtain the views of people, professionals or staff. One staff member told us, "I haven't had a survey since 2017."
- Staff meetings were held and minutes were available. These had not always been held at regular intervals.
- People did not always wish to attend meetings although it was not always clearly documented when meetings had been offered but declined.

Continuous learning and improving care

- The provider had failed to sustain the improvements made at the last inspection. There was limited scope for improvement or innovation due to instability in the leadership of the service.

The lack of effective governance systems and record keeping compromised the quality and safety of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Working in partnership with others

- There were some examples of the provider working in partnership with others and engaging with the local community. This included the sourcing of work placements and volunteering opportunities.

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 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA RA Regulations 2014: Person-centred care Care and treatment was not always designed and delivered in a way which met people's individual needs and preferences. Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Individual risks and risks relating to environmental safety including infection control, had not always been assessed, adequately monitored or mitigated. 12 (1)(2)(a)(b)(d) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance An effective system to assess, monitor and improve the quality and safety of the service, and to assess monitor and mitigate risks

relating to the health, safety and welfare of service users and others was not in place. There were shortfalls and omissions in records relating to people. An effective system to obtain the views of people and their representatives was not in place.

Regulation 17 (1)(2)(a)(b)(c)(e)(f).

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 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 Care Quality Commission (Registration) Regulations 2009 Notifications had not been sent of all incidents reported to or investigated by the police, or all allegations of abuse. Regulation 18 (2) (e) (f)

The enforcement action we took:

We issued a fixed penalty notice, which the provider has since paid.