Bupa Care Homes (CFHCare) Limited

Wentworth Croft Residential and Nursing Home

Inspection report

Bretton Gate
Peterborough
Cambridgeshire
PE3 9UZ
Tel: 01733 269200
Website: www.legalcareservices@bupa.com

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 30 October and 12 November 2014. A breach of three legal requirements was found. This was because there were not always sufficient numbers of staff on duty to meet the needs of people living in the service. The on-going quality monitoring system had not made the improvements required to protect people against the risk of insufficient staffing levels. People's safety equipment was not always in the correct place. The manager had not notified the Care Quality Commission of incidents, events and changes that affect the service or the people who used it that they were legally required to.

After the comprehensive inspection the provider wrote to us to say what they would do to meet the legal requirements in relation to the breaches.

We undertook this unannounced focused inspection on 31 July 2015 to check that the provider had followed their plan and to confirm that they now met legal requirements.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wentworth Croft Residential and Nursing Home on our website www.cqc.org.uk.

Wentworth Croft Residential and Nursing Home is a registered care home that provides accommodation for

Summary of findings

up to 156 mainly older people some of whom live with dementia, who require nursing and /or personal care. The service offers accommodation over one floor within four separate units called, Woolsack, Hayward, Harvester and Yeoman. Each unit has single occupancy bedrooms with ensuite facilities and there are internal and external communal areas, including lounges, dining areas and gardens for people and their visitors to use. There were 92 people living in the service at the time of the inspection.

The home did not have a registered manager in post at the time of inspection. The current manager was in the process of applying to become the 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.

At our focussed inspection on 31 July 2015 we found that the provider had followed their plan which they told us would be completed by 01 April 2015 and legal requirements had been met.

There was evidence that people were supported by sufficient numbers of suitable staff to meet their care, support and health care needs. Staffing levels had been assessed in relation to the dependency levels of people who lived in the home. People's safety equipment such as care call bells and sensory alarm mats were in place to alert staff when help was required.

The on-going quality monitoring system now had actions in place to identify and manage any shortfalls in staffing levels due to staff sickness and absenteeism.

Actions had been taken by the manager to notify the Care Quality Commission of any incidents, events and changes that affected the service, or the people who used it.

Summary of findings

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 

We found that action had been taken to ensure the service was safe.

There were enough staff to meet people's health care and support needs safely.

This meant that the provider was now meeting the legal requirement.

Whilst improvements had been made we have not revised the rating for this key question to improve the rating; to improve the rating to 'Good' would require a longer term track record of consistent safe staffing levels as determined by people's assessed dependency needs.

We will review our rating of this key question at the next comprehensive inspection.

Is the service well-led?

Requires improvement 

We found that action had been taken to ensure the service was well-led.

On-going quality monitoring process highlighted areas for improvement such as shortfalls in staffing levels; actions were now taken to make the required improvements.

The Care Quality Commission was now informed as required of events and incidents that happened within the service or to people living in the service.

This meant that the provider was now meeting the legal requirement.

Whilst improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of on- going quality monitoring and actions taken to improve the quality of the service and delivery of care. We would need to see longer term evidence and that the provider had notified the Care Quality Commission of all incidents and events that they were legally required to.

We will review our rating of this key question at the next comprehensive inspection.

Wentworth Croft Residential and Nursing Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Wentworth Croft Residential and Nursing Home on 31 July 2015. This inspection was completed to check that the improvements to meet the legal requirements planned by the provider after our comprehensive inspection of 30 October and 12 November 2014 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 well-led. This is because the service was not meeting legal requirements in relation to those questions.

The inspection was undertaken by two inspectors.

Before the inspection we looked at all of the information that we held about the service. We asked the provider to complete and return a provider information return (PIR). This form asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We looked at other information we held about the service including information received and notifications. Notifications are information on important events that happen in the service that the provider is required to notify us about by law. We also looked at the provider's action plan which we received on 18 February 2015.

During our inspection we spoke with the manager, area manager, head of care, two unit managers, deputy unit manager, bank nurse, five care workers, two activities co-ordinators, five people and five people's relatives.

We looked at staff rotas for the day of inspection and recent weekends to determine staffing levels. We looked at people's dependency assessments and the manager's weekly walk around checklist.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Wentworth Croft Residential and Nursing Home on 30 October and 12 November 2014 we found the manager had been unable to cover the shortfall in safe staffing levels from their pool of bank staff and agency staff. Due to these concerns we then looked at staff rotas for the month of October 2014, and found other examples of when there was not a full quota of staff on duty. Observations throughout the inspection showed that staff were 'task orientated' to try to ensure that people's needs were met as there was a number of staff absent. This meant and our observations throughout the day showed that there were not enough staff to respond to people's health, care and support needs in a timely manner.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focussed inspection on 31 July 2015 we found that the provider had followed the action plan they had written to meet the shortfalls in relation to the requirements of the Regulations described above.

Our observations showed that there were enough staff in the service to support people safely. We saw that although staff were busy they had enough time to support people with their health, care and support needs in an unrushed manner. One staff member told us, "The staffing [levels] here [have] definitely improved, communication and staff morale is good……Every day is different, it's always busy but we try to socialise with residents." They went on to say, "The management team have improved things, we can always get staff in when you ask – never left short." A person told us, "The staff are kind and come as soon as they can to help me; there is always enough staff to help me. I couldn't wish for better." Another staff member said, "Management have taken notice when we are in need of extra staffing in the last six months, staffing levels feel safer."

We saw that people were not hurried when supported by staff and staff spoke socially with people whilst they were assisting them, for example when helping them to move, assisting with their meal or with their activity. Since the last inspection, the management of the service had carried out a complete re assessment of people living in the service and their health, care and support needs. This was to ensure that people had been placed onto the correct unit which met their requirements. This meant that people were now placed on units with suitably trained and sufficient numbers of staff. There was a method which was used by the manager to check people's dependency levels so that there would be sufficient and suitable numbers of staff available to meet their needs. Staff we spoke with told us that they did request additional staff when needed and that the number of staff increased when necessary.

Observations showed that during this focused inspection, staff had more time to spend with people who were at risk of becoming anxious. We saw a person known to be at risk of increased anxiety at meal times, being encouraged by staff in a kind and patient manner to sit at a dining table at lunch time with their 'friends'. This interaction and input from staff meant that the person was able to feel reassured and we saw that their level of anxiety appeared reduced.

People were supported with individual and group interests by the activities co-ordinators and staff. We saw an impromptu dance taking place on one of the units with a staff member encouraging people to dance with their support to the music playing, should they wish to do so. A relative we spoke with told us that they knew that the manager was trying hard to recruit permanent staff. They told us that this was communicated to them at relatives meetings they had attended and that this communication was also on notice boards for people and their visitors to read. They said, "The new person [manager] is doing a good job…..trying to advertise for staff and trying to fill vacancies….making serious efforts and have turned a corner [with staffing levels]. People can't be better looked after with the staff they have got…they are improving."

However, staff and relatives we spoke with still had some concern about the number of agency staff used within the service to cover some staffing level shortfalls. A relative told us that they understood the need for agency staff and that they felt their family member was safe. They went to say that they would prefer permanent staff instead of agency, because agency staff would not know their family member. A staff member said, "Agency staff need more supervision [but] teamwork is very good, people's needs are met [but] it's just frustrating." We spoke with the manager, head of care and area manager about this. They told us that they

Requires improvement

Is the service safe?

were continuing to work to reduce the number of care hours needed to be covered by agency staff. Since the last comprehensive inspection, records we looked at showed that the number of agency staff used had decreased.

Requires improvement

Is the service well-led?

Our findings

At our comprehensive inspection of Wentworth Croft Residential and Nursing Home on 30 October and 12 November 2014 we found that some of the quality assurance monitoring was ineffective in taking the necessary improvement actions to ensure that people were supported by a safe level of staffing. We also found that people's care call bells and sensory alarm mats were not always in place. This had not been identified as an area requiring improvement by the manager's on-going quality monitoring systems. This meant that there was a risk that people would be unable to use these safety devices to request assistance from staff.

This was a breach of Regulation 10 (1) (a) (b) 2 (b) (iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection of 31 July 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulations described above.

Since our comprehensive inspection on 30 October and 12 November 2014 a new manager had been appointed. Their application to become the registered manager with the Care Quality Commission was in progress. A staff member told us that they felt, "A lot more supported." Another staff member said, "We see [manager] in here a lot and she [has] improved things, the manager has organised things more and is available." Staff and most of the relatives we spoke with told us that the manager spent time speaking to people, their family members and staff.

The manager had started a weekly walk around on each unit and documented their findings and any areas for improvement on a checklist. This checklist now formed part of the services on-going quality monitoring system. This walk around was in place to capture any concerns that would not be identified by existing quality monitoring audit tools. This and the work undertaken on reassessing people's dependency levels meant that staffing level shortfalls and/or people's safety equipment not being in place were identified a lot quicker and action to improve taken.

At our comprehensive inspection on 30 October and 12 November 2014 we found that staff were not aware of all of the events and incidents that they were legally obliged to notify the Care Quality Commission about.

This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

At our focused inspection of 31 July 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulations described above.

The manager was able to demonstrate their knowledge around notifications to be submitted to the Care Quality Commission. Records we looked at confirmed to us that notifications had been received by the Care Quality Commission about events, incidents and changes that affect a service and the people who use it.