Care Quality Commission

Henson Healthcare (Whitby) Limited

Whitby Court Care Home

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

Whitby Court Care Home provides accommodation for up to 50 people who requiring nursing and personal care. The home mainly provides support for older people and people who are living with dementia. The accommodation is arranged over two floors and there is a passenger lift to assist people to get to the upper floor. There were 24 people living at the home at the time of our inspection.

This was an unannounced inspection, carried out on 17 November 2014 following concerns raised about the quality of care people received at the service by people who did not wish to be named.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had recently within days of our inspection terminated there employment with mutual agreement by the provider.

This was the first inspection since the provider was registered on 18 February 2014.

Although people told us that they felt safe in this home we looked at incident records and found where incidents had occurred sufficient action had not been taken to prevent further incidents occurring again. We also found

Summary of findings

medication was not safely recorded and administered which placed people at possible risk of harm. Support plans we looked at to manage complex behaviours did not contain sufficient detail to ensure people's safety and well-being.

People told us that they, and their families, had been included in planning and agreeing to the care provided. We saw that people had an individual plan, detailing the support they needed and how they wanted this to be provided.

Staff we spoke with told us they had not received any training or induction since working at the service and equally had received no supervision from the registered manager. This had been highlighted during the providers' review of the service and the operations manager had commenced in addressing the areas of concern.

People were treated with kindness, compassion and respect. The staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home but also saw instances where staff struggled to engage people in any meaningful activity.

People's health, care and support needs were assessed. Individual choices and preferences were discussed with people who used the service and/or a relative. Care plans were reviewed on a monthly basis or when there had been a change in people's needs.

People who use the service and their relatives spoke very positively about the operations manager. However staff told us they did not always have the skills to work with people who had complex behaviours and needs. And they lacked appropriate training to ensure people's needs were appropriately met.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to planning care effectively, managing medication, staff training.

You can see what action we told the provider to take at the back of the full version of the report

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?
The service was not safe.

Risk assessments in place to ensure people's needs were adequately met were not detailed to ensure staff were able to meet people's needs.

Medication was not safely recorded and administered.

Requires Improvement

Is the service effective?
The service was not effective.

Staff working in the service did not receive sufficient training to meet the needs of people who used the service.

Care plans and risk assessments were up to date and people received support where required from other professionals.

Requires Improvement

Is the service caring?
The service was caring.

People's care was not always holistic but staff had a good understanding of people's needs.

We observed staff talking to people in a kind and compassionate manner.

Good

Is the service responsive?
The Service was responsive.

People's health, care and support needs were adequately assessed. Individual choices and preferences were discussed with people who used the service and/or a relative.

People felt listened to. The service had a complaints process and held meetings to ensure people's needs were met.

Good

Is the service well-led?
The service was well led.

People who use the service and their relatives spoke very positively about the operations manager. However staff told us they did not always have the skills to work with people who had complex behaviours and needs. The service had a plan in place to address the shortfalls.

Audits were carried out in relation to infection prevention and control, the environment and the medication systems. This helped the manager make sure the systems in place to keep people safe were working as they should be. However audits were not adequate because we found people did not always experience safe and effective care and improvements were required.

Good

Whitby Court 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.

We visited the home on 17 November 2014. Our visit was unannounced and the inspection team consisted of one Adult Social Care inspector. The day of our visit focused on speaking with people who lived in the home and their visitors, speaking with staff and observing how people were cared for. The inspector looked in detail at some areas such staff records and records related to the running of the service. Make reference to health professional you spoke with

During our inspection we spoke with four people who lived in the home, three visitors, eight care staff and the operations manager. We observed care and support in communal areas, spoke with people in private and looked at the care records for four people. We also looked at records that related to how the home was managed.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

We spoke with four people who use the service one person's relative and two health professionals. People we spoke with told us they felt safe at Whitby Court. One person told us "it's a lovely place, the girls are good and I enjoy living here". One person's relative told us "we are very happy with the care our relative receives, the home is beautiful and staff are very good".

Staff we spoke with told us they had received training in safeguarding vulnerable adults and were clear about how to recognise and report any suspicions of abuse. Staff were also aware of the whistle blowing policy and knew the processes for taking serious concerns to appropriate agencies outside of the home if they felt they were not being dealt with effectively. This showed us staff were aware of the systems in place to protect people and raise concerns.

We looked at the system in place for monitoring and reporting incidents. Where incidents in the home occurred details were recorded on the services electronic system and information was sent off to the organisations operations manager to collate data regarding the service. The service was able to produce data regarding the number and types of incidents which had occurred in order to have forward planning in relation to reducing the number and types of incidents.

However we did find one incident which had occurred in the home which had not been reported to external authorities such as CQC. The service has a legal responsibility to report such incidents and failure to do so means that people may not be protected from harm through appropriate measures. We spoke with the operations manager who acknowledged our concerns and told us that some of the issues of reporting were failures of the registered manager as they believed relevant authorities had been notified.

We spoke with the operations manager and asked how the information was being used to learn from incidents and make forward planning. We found during the time of our inspection improvements to the analysing of information was required. Although the system was able to generate reports which could be used for future planning of care for people it had not. The operations manager acknowledged our concerns and told us they were in the process of developing a system so data could be used to improve quality of care and safety of people using the service.

We looked at the risk assessments and care plans of five people across the home and found improvements were required.

Needs assessments on care files which had been reviewed were not updated with changes in assessed needs for people. For example one person had significant deterioration in mental health, a new formulation plan had been written up along with guidance provided by health professionals which had not been followed. We spoke with two visiting health professionals regarding the person's care and they expressed concerns that the service was not following the guidance provided and this was contributing to the person's distress.

The service had not introduced strategies or interventions to support the person with their cognitive difficulties. Health professionals provided further advice and guidance to the service during our inspection to ensure the person's needs were appropriately addressed.

This is a breach of regulation 9 of the Regulated activities regulations 2010.

We looked at the systems for the management of medicines at the service. The operations manager told us they used a monitored dosage system from a pharmacy. However when we inspected medicines we found this was not accurate as tablets were stored in original boxes in people's bedrooms in locked metal cabinets which were hung on the wall.

There were records to demonstrate medicines were checked when the service received them so any discrepancies were promptly addressed. We looked at how medicines were being stored at the service and found they were secure and were stored according to manufacturer's recommendations.

We looked at the care records of four people and found where they had allergies to certain medicines this was recorded clearly on the person's records. We also found where people were prescribed "as and when required" medicines there was a clear protocol in place to ensure nursing staff were aware of the circumstances in which the medicines should be administered.

Requires Improvement

Is the service safe?

We looked at the arrangements in place to ensure medication stored in the fridge was safe to use. We saw medication was not always dated when it had been opened and we did find that service was using multiple boxes of medication as a result. This meant there was not a clear system for the use of medication.

We looked at how medicines were administered and found this was not always carried out safely. We checked the medicines stock for four people and looked at their Medication Administration Records (MAR) and found that medicines were not always signed to reflect the prescriber's instructions. This meant staff were not always administering medication appropriately.

We brought our concerns t the immediate attention of the provider and operations manager who acknowledged our concerns and told us they would carry out a full audit and ensure a Monitored Dosage System was introduced as previously planned to avoid further discrepancies.

This is a Breach of Regulation 13 of the Regulated Activities Regulations (2010)

We looked at the recruitment records for three staff members. We found that recruitment practices were safe and relevant checks had been completed before staff had worked unsupervised at the home. We spoke with a five members of staff who confirmed a Disclosure and Barring Service (this is a check carried out to determine people's criminal record status and also ensure people were not on a list which prevented them from working with vulnerable children and adults) check and references had been completed before they started work in the home. This meant people who lived at the home were protected from individuals who had been identified as unsuitable to work with vulnerable adults.

We asked the operations manager how they decided on staffing levels. We were told staffing was based on the dependency levels of people who lived in the home and was under constant review. As people's needs changed or when people moved into the home staffing would be adjusted. The service also used a tool to identify safe staffing levels.

We looked at a random selection of staff rotas for three weeks prior to the inspection and saw staffing levels were consistent. We had been told prior to the inspection that often there was no nurse working in the home. The rota's and information we received from staff showed there was always a nurse on duty to ensure people's needs were met.

Staff we spoke with told us they felt there was always sufficient staff on duty and people were well cared for. We found the atmosphere in the service relaxed and staff were not appearing rushed . One person who we spoke with told us "you don't have to wait for anything I call for help and they come immediately".

We toured the building looking at areas such as bathrooms and communal living areas and checked for the arrangements in place for cleanliness and infection control.

We found the service had daily and monthly cleaning schedules and these were monitored through regular monthly auditing to ensure standards in the home were maintained and people were not placed at risk of infection due to poor hygiene practices.

Overall the home was clean to the eye, and we observed staff using hand gels to minimise the risk of infection, and there was a supply of soaps in bathrooms for people to wash their hands. However we did find there were no bins in the bathrooms to place used hand towels. The operations manager told us they would address this.

We also looked at how the building and equipment were maintained. We found the service kept clear records of maintenance required and where equipment such as hoists required servicing these were done in accordance with the manufactures instructions. The service kept records of all maintenance areas. A recent audit in October 2014 identified no concerns.

Requires Improvement

Is the service effective?

Our findings

We checked to ensure the service was compliant with the requirements of the Mental capacity Act 2005 and the Deprivation of Liberty Safeguards (DOLS). We found the service was in the process of submitting applications under DOLS for some people using the service.

We looked at staff training and induction. Three staff on the day of our inspection told us they had received no training in areas relevant to their role for example, moving and handling, infection control, dementia awareness and health and safety since coming to work for the organisation. Staff told us they had received training in previous employment but had not received anything since coming to work at the home. The operations manager confirmed what we had been told by staff and said this was an immediate area for improvement.

Staff we spoke with told us the training they had received in previous employments did not support them entirely with managing people with complex behaviours and needs. They told us this often impacted on their ability to give high standard care as they often struggled with engaging people in meaningful activities or struggle to understand the complex behaviours of people. We observed during our visit staff struggling to engage people who had complex needs.

Our observations of people's care demonstrated that although staff were caring they did find it difficult to engage people. We observed staff only interacting with people when something negative was happening such as a person shouting for attention or wandering. Staff did not proactively seek out engagement with people who displayed distress.

We observed a person who had become distressed throughout the day because of confusion of where they were and what was expected of them. The staff team working with the person repeatedly asked the person to "come and have a cup of tea", or "let's take you to your room".

We spoke with the operations manager who acknowledged our concerns and told us they had identified staff required further support in training . The provider and operations manager were very clear with us the care which was being delivered was not part of their forward plan. The service had a purpose built kitchen, a beach room which could be used as a cinema room, library, games room and salon all of which were there for staff to use to engage people meaningfully providing a person centred quality of life.

However during our inspection none of these facilities were being used and although staff had a number of opportunities to use the facilities during the day they did not. The service was very task driven and did not put people at the centre of care.

The operations manager told us staff appraisals had been planned, and since the departure of the previous registered manager they had taken responsibility of ensuring staff supervision. Records provided confirmed staff had received supervision from the operations manager.

Not ensuring staff receive adequate training places people at risk of receiving inappropriate or unsafe care.

This is a breach of Regulation 22 of the Regulated Activities Regulations 2010

We looked at how admission was managed and found people received a holistic care assessment to ensure the service was able to meet the person's needs and manage the person's care effectively and safely.

We looked at four care plans and saw people's preferences in relation to food and drink had been recorded, together with any special dietary requirements. When we spoke with the cook they confirmed staff kept them up to date about people's dietary needs and preferences and these were documented and kept in the kitchen. They also explained staff could order any food they needed and could change the menu to accommodate people's preferences.

We also observed people were offered cups of tea or coffee throughout the day. Jugs of juice or water were on the tables or in private bedrooms or lounge areas for people. People were supported to make their own drinks as the service had specially fitted taps which people could use to make cups of tea or other hot drinks if they wished.

We looked at how the service engaged with other services. In the four care plans we looked at we saw people had been seen by a range of health care professionals, including, GPs, specialist nurses, community matrons and podiatrists. Care staff we spoke with told us the nursing staff were quick to respond if people's needs changed. However professionals visiting the service did tell us advice and guidance was not always followed.

Good

Is the service caring?

Our findings

One person's relative we spoke to told us they were unrestricted in visiting times and could visit whenever they liked, and they were able to spend as much time with their relative as they wished.

We looked at the care plans for five people who lived at the home. They all contained some information about people's personal preferences and likes and dislikes but not all of them contained a life history. However care plans were easy to follow and staff we spoke with were able to tell us about people's care needs and the support they provided to people.

Staff demonstrated an in-depth knowledge and understanding of people's preferences and routines despite some lack of information in people's care records.

We saw staff were patient and kind to people, they approached people with respect and worked in a way that maintained people's dignity. We saw other examples where staff were assisting people they explained what they were doing and why. We saw this put people at ease.

On the ground floor unit we did observe people were sometimes not listened too. Staff struggled to manage when people were distressed and repeatedly addressed the distress by offering "cups of tea" and a "sit down" as opposed to other coping strategies. However we did find staff were well intended and recognised their own shortfalls. They had told us they required additional training to ensure people were better supported and cared for.

We looked at the arrangements in place to support people make difficult decisions where they may not have had anybody to represent them. Advocacy services to support people were in place if they need additional help in making decisions. No person at the time of our inspection was actively using advocacy services.

We looked at the care planning process in the home and some people had "end of life" arrangements which had been put in place detailing their requests should they become to unwell to make decisions for themselves. This part of people's care plan was reviewed on a monthly basis where a plan was in place.

We spoke with staff about the arrangements in place to meet the needs of certain groups such as ethnic minority or lesbian, gay and bisexual people. The service had an equalities and diversity policy in place and we were given examples of how the service met the needs of people of particular faiths.

We asked people who use the service what activities they participated in to ensure they remained active members of their community. People told us they did not participate in many activities and this was there choice. During our inspection people were engaged in reading magazines and talking with staff. The operations manager identified this as an area for improvement and told us an activities coordinator had been recruited to work in the home and was due to start work soon which would increase stimulation for people.

Good

Is the service responsive?

Our findings

We used our SOFI to observe how people were cared for. Although we found many positive interactions between staff and residents we also found areas for improvement. For example one person was distressed on a number of occasions during our inspection and although staff attended to the person they were often left isolated in their bedroom and repeatedly told staff they were confused. We found staff often walked away from the person without offering an activity or sufficient engagement to relieve distress. The service did have a plan in place to provide staff with further training to ensure people could be appropriately engaged with.

The operations manager told us an assessment was completed before people moved into the home to make sure staff could meet the person's care needs. We saw assessment information in the four care files we looked at. We were told by nursing staff and care staff care plans were reviewed on a monthly basis to check if any changes needed to be made to the way people's care and support was being delivered.

Where people displayed challenging and complex behaviours there were no detailed plans in place informing staff of the strategies and interventions to use when managing their behaviour. We talked with the operations manager about the use of cognitive stimulation programmes to support people as well as specific training for staff in managing complex needs. We found there was little support to people with cognitive impairments. For example there was no information displayed that would assist people with day/month and year, what time it was or where their bedroom and bathrooms were. The operations manager acknowledged our concerns and told us they would make improvements.

We looked at how complaints in the service were managed. We saw the complaints procedure was on display in the home.

Four people we spoke with told us they had no reason to complain about the service but if they were concerned about anything they would tell a member of staff.

We looked at the complaints and concerns log and saw what action staff had taken to resolve any issues that had arisen. This meant staff were recognising complaints and taking action to resolve them to the complainant's satisfaction.

The operations manager told us the home carried out regular meetings with people who use the service and their relatives. We saw the minutes of the previous meetings held and found they contained information about changes to the service such as the new management arrangements following the departure of the registered manager.

Good

Is the service well-led?

Our findings

The Home did have a registered manager but due to concerns identified by the provider they had left the service by mutual agreement. The operations manager was overseeing the home at the time of our inspection until a new manager had been recruited.

A new registered manager had been recruited following our inspection and was in post at the time of publication of this report.

Five members of staff we spoke with talked highly of the operations manager, they told us “everything is getting better since the manager left, he is good and we feel listened too”.

Staff meetings were held and gave staff the opportunity to feedback on the quality of the service. We saw minutes from the meeting held in November 2014 and saw staff had been provided information on the future management arrangements. It was also identified the culture in the home required improvement. For example staff worked in a task orientated way which meant care was not personalised or person centred, there was an emphasis on staff to use the facilities provided within the home to maintain people’s independence and skills. The provider told us they were starting to spend more time in the home to ensure staff were working to the standards expected of them.

The operations manager told us they had a strong presence in the home because they were conscious there was no manager they told us they spent most days in the service and often worked until late at night. The operations manager and provider told us about the culture in the home and an emphasised a need for change. They told us staff worked in task orientated ways and this was not a focus for the service and they were required to work in a more meaningful person centred manner.

There was a system of audits that included; the kitchen, environment, medication, infection control and equipment. We saw care plans and risk assessments were not always reviewed and amended to reflect people’s changing care needs and although this had been identified by the service sufficient steps to improve care had not been embedded during the time of our inspection.

Accidents and incident reports were recorded, securely stored. This meant any trends or patterns would could be identified and appropriate action taken to reduce risks to people who lived in the home.

The service had a plan in place to make improvements in the way care was planned and delivered for those with cognitive impairments, as well as a comprehensive programme of training for staff who had been recruited and not received an induction.

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 did not take formal enforcement action at this stage. 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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People's needs were not always assessed and care and treatment was not always planned and delivered to meet the needs of people who use the service. Reg (9) (1) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The service did not have appropriate arrangements in place for the safe handling and administration of medication.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The service did not have staff with sufficient skills and competence to meet the needs of people.