Care Quality Commission

Wall Hill Care Home Limited

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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?	Good
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 27 April 2015 and was unannounced. At our previous inspection in June 2013 we found no concerns in the areas we looked at.

The service provided accommodation and personal care to 34 people. At the time of the inspection there were 34 people using the service.

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.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLs) and to report on what we find. The Deprivation of Liberty Safeguards are for people who cannot make a decision about the way they are being treated or cared for and where other people are having to make this decision for them. The provider did not

Summary of findings

consistently follow the guidance of the MCA and ensure that people who required support to make decisions were supported and that decisions were made in people's best interests.

People who had specific dietary needs did not always receive the nutrition they required to maintain a healthy, balanced diet.

We found three breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of the report.

Staff told us they knew what constituted abuse and that they would report it, however we saw two recorded incidents that should have been considered as suspected abuse that had not been reported or acted upon.

Lessons were not always learned and risks to people following harmful incidents were not minimised through the use of effective risk assessment.

Medicines were safely stored and administered, however records had been altered and medicines were not always given at the prescribed times.

There were sufficient trained staff who had been recruited through safe recruitment measures to meet the needs of people and keep them safe. Staff told us they felt supported to fulfil their role through regular training and supervision and appraisal.

People had access to a range of health care professionals and were supported to attend appointments when required.

People who used the service told us they were happy and felt well cared for by the management. Interactions between staff and people were kind and compassionate. People's privacy and dignity were respected.

People were involved in how the service was run, for example through effective communication and regular meetings.

Community links were maintained through regular community visits and planned entertainment. People were encouraged to be as independent as they were able to be and kept informed of any changes that may affect the running of the service.

People who used the service and their relatives told us the management were open, friendly and receptive. People knew that any complaints they had would be dealt with appropriately.

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 consistently safe. Suspected abuse was not always recognised and responded to. Risks were not always minimised following incidents that may have caused people harm.

There were sufficient staff to meet people's needs safely. Medicines were stored and administered safely, however records of medication administration were not correctly maintained.

Requires improvement

Is the service effective?

The service was not consistently effective. The principles of the MCA were not consistently followed to ensure that decisions were made in people's best interests. People who had specific dietary needs did not always receive the nutrition they required to maintain a healthy, balanced diet.

People had access to a range of health care professionals and were supported by effective trained staff.

Requires improvement

Is the service caring?

The service was caring. People were treated with kindness and compassion and their privacy and dignity was maintained.

People were involved in how the service was run through effective communication and regular meetings.

Good

Is the service responsive?

The service was responsive. People received personalised care that met their individual needs. Links to the community were maintained and opportunities to join in chosen activities were available.

People knew who to and how to complain if they were not happy with the care they received.

Good

Is the service well-led?

The service was not consistently well-led. Current guidance was not always followed to keep people safe and to ensure a continuous improvement. Systems were in place to monitor the quality of the service however they were not always effective.

People and their relatives respected the managers and provider of the service and told us they were approachable. Staff told us they felt supported by the management to fulfil their role through regular training and appraisals.

Requires improvement

Wall Hill Care Home Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 27 April 2015 and was unannounced.

The inspection team consisted of three inspectors.

We looked at the information we held about the service. This included notifications of significant events that the manager had sent us, safeguarding concerns and previous inspection reports.

We spoke with most people who used the service and observed their care. We spoke with the managers, provider and six members of staff. We looked at nine people's care records, staff rosters and the staff training records.

We spoke with two relatives of people who used the service and a visiting health professional to gain their views.

Requires improvement

Is the service safe?

Our findings

All but one person we spoke with told us they felt safe with the care they or their relative received. However the one person told us they didn't feel safe as another person who used the service often wandered into their bedroom. This person said: "I don't feel safe as I am frightened of one of the other residents. They wander about and have walked into my bedroom on occasions". When we discussed this with the manager they knew that this was an issue but no action had been taken to minimise the risk of it happening.

All the staff we spoke with knew what to do if they suspected a person who used the service had been abused. One staff member told us: "I would contact the manager and provider after making sure people were safe. I know that concerns are referred to the local authority. The contact details and phone numbers are in the office. I have never seen anything of concern while I have been working here". However we saw records that showed on two occasions one person who used the service had potentially abused two other people. We saw that immediate action was taken to stop the alleged abuse but no referral was made to the local authority to investigate and the person's risk assessment had not been up dated to minimise the risk of the incidents happening again.

Some people accessed the community alone and others managed their own medication. The manager told us that they encouraged people to be as independent as they were able to be. We saw that there were risk assessments in place for these activities, however they did not state how to minimise the risks to people whilst undertaking these activities. We saw that on one occasion one person had been supported back to the service by a member of the public when they had got into difficulty. This person's risk assessment had not been up dated to reflect the incident and the risk of the same thing happening again had not been reduced.

These issues were a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed people's care and saw that people's needs were met in a timely manner, there was sufficient staff to safely meet people's needs. One person commented on sometimes having to wait for assistance but other people said they felt there was enough staff to meet people's needs. All the staff we spoke with told us that there was enough staff to care for people safely. The rota's showed that the staffing levels reduced slightly at the weekend. We asked staff why this happened and they told us that they didn't bathe people at the weekends so one staff member was reduced. We discussed this with people, staff and management and they assured us that if people needed or requested a bath or shower at the weekend they would be able to have one.

Staff told us that the manager had followed safe recruitment procedures, checks to ensure that people were suitable and fit to work had been carried out prior to them being offered a position. New staff had a period of induction prior to starting to work unsupervised. One new member of staff told us: "I shadowed other staff and did some in house training for two weeks before I worked alone". This meant that safe systems were in place to ensure people were being cared for by staff who were of good character and competent in their role.

People told us they had their medication at the prescribed times. We saw safe systems were in place to store and administer people's medications. Photo identity was evident on people's medication records to support staff to ensure that staff identified the correct person when administering medication. People were prescribed pain relief and it was clearly recorded when it had been administered. However on one person's medication record we saw that a member of staff had used correction fluid to change the prescribed times of medicine administration, which is contrary to the guidelines of safe record keeping.

Requires improvement

Is the service effective?

Our findings

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLs) and to report on what we find. The Deprivation of Liberty Safeguards are for people who cannot make a decision about the way they are being treated or cared for and where other people are having to make this decision for them. The manager told us that they were not restricting anyone from anything and hadn't needed to make a DoLS referral to the local authority. In discussions with the manager they accepted that the DoLS legislation covered areas that they had not considered such as constant supervision of people, restricted access to the kitchen and the use of bed rails. This meant that some people could have been unlawfully restricted of their liberty.

One person who lacked mental capacity, had become disruptive to others at meal times. Their care plan stated that they were to have their meals in their room. A best interest meeting had not been held to ensure that this was in the person's best interest and it was not a restriction of their liberty. Another person with mental health issues and who lacked capacity insisted on having their medication at times that suited them and not as prescribed by their clinician. Staff were administering their medicines at the time the person requested. This had not been discussed and agreed as in this person's best interests with the person's GP or psychiatric nurse. This meant that these people were at risk of receiving care and support that was ineffective.

One person had made an advanced decision not to be resuscitated in the event of their heart stopping. However we saw three other people had a 'Do Not Attempt Resuscitation' form on their care record. Each one had been signed by their GP and it was recorded that the decision had not been discussed with the person or their representative, this was confirmed by the manager. This meant that people or their representatives were not being involved in the decision about receiving lifesaving treatment in the event of a medical emergency. This meant that the provider was not following the guidance of the MCA and ensuring that people are fully involved in the decision making about their care, treatment and support.

These issues constitute a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the staff were effective in their role. Staff received on-going professional development through regular training and appraisal. Staff we spoke to demonstrated a comprehensive understanding of their role. A member of staff told us they had an induction prior to starting work at the service, however they said they had not had time to look at individuals' care plans and risk assessments. When asked they did not know the needs of all the people who used the service but confirmed they had supported people with their care needs. This meant that people were at risk of receiving care that was unsafe and ineffective.

People who used the service told us that the food was okay. A member of staff told us that three people were vegetarians. We asked what the vegetarian option was for that day and were informed it was vegetables as other people were having stew and dumplings. We asked what the vegetarian option was for the following day and we were told it was vegetables as the other option was turkey. At lunchtime we saw that two of the three people who wanted a vegetarian diet had a bowl of dry cooked vegetables and a piece of bread. We asked one person if they were happy with their meal, they said: "It's okay". We noted that these two people left their food and were not offered an alternative. The manager told us that they had tried other vegetarian food but people had not liked it, however they liked food such as cheese pie, which was on the menu on other days. Another person had a bowl of soup, they told us: "I don't like the main meal so they give me soup. It's okay".

One person had been prescribed a food supplement as they had become unwell and there had been a reduction in their eating and drinking. The provider had not received the supplement and we saw that this person's health continued to deteriorate. Records showed that they were having sips of juice and the occasional mouthful of food. Although the amount of fluid the person was having was recorded it did not identify how much this person should drink to reduce the risk of them becoming dehydrated. This person was being cared for in bed and had been assessed as being at high risk of pressure ulcers, maintaining a healthy diet of food and fluids is essential when people are at risk of sore skin.

Requires improvement

Is the service effective?

These issues constitute a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

People had access to professional health care when required. One person told us: "I see my CPN (community psychiatric nurse) every two weeks, they are very good". A relative told us that staff supported their relative on hospital appointments when required. We spoke to a visiting district nurse who told us that staff were proactive and contacted them quickly when there was a change in a person's condition. They told us: "We have cared for people between us at the end of their life and it has been excellent, the person has remained comfortable throughout".

Good

Is the service caring?

Our findings

People who used the service and their relatives told us that staff were kind and caring. A relative told us: "They are wonderful here, they treat [my relative] like their own elderly relative". Another relative told us: "[My relative] would tell me if they weren't happy here, they love one of the night staff who always takes them a cup of tea if they are having a restless night. It's the little things that matter isn't it"? The same relative also said: "The care is good, we are very happy with it".

People sat chatting between themselves in the lounge areas and we saw that relationships had been forged between people. We observed that staff spoke with people in a gentle, kind and considerate manner. One person had a fall and staff supported them to stand in a patient and attentive manner, remaining calm as the person had become slightly anxious. Staff offered them reassurance throughout.

Relatives told us they were kept informed and were fully involved in the care of their relative. People told us that relatives and friends could visit at any time. One relative told us: "We took [my relative] to a family party and we arrived back very late, the night staff met us at the door and helped us with no issues".

Regular resident meetings were held and we saw that people were kept up to date with changes within the service, such as staff leaving and new staff starting. There was a Wall Hill newsletter on the wall in the reception area which also informed people of any planned changes and activities that were available.

People's dignity and privacy was respected. Everyone had their own room or shared a room which were personalised to their individual preferences. We saw a privacy curtain was in the process of being cleaned for use in the shared room. People were escorted discreetly to use the toilet facilities when required. We saw a person who was being cared for in bed, looked comfortable and well cared for with clean fresh linen on their bed.

People were supported to be as independent as they were able to be, people walked freely around the home with the use of mobility aids when required. We saw one person knocked on the kitchen door and asked for a cup of coffee, this was agreed and provided with no hesitation by the kitchen staff.

Good

Is the service responsive?

Our findings

People and their relatives told us they were happy with the care they received. A relative told us:; "[My relative] chose to come here as they had visited people here and liked it, they were able to choose the room they have".

People told us they were able to make choices about what they wanted to do such as what time to get up and go to bed. We saw that several people had newspapers delivered and we were informed that these were paid for by the provider.

On the day of the inspection there were no planned recreational activities, however the hairdresser was present and several people enjoyed having their hair done. One person told us: "You feel so nice when you've had your hair done don't you?"

We saw that there was a programme of planned activities which mainly consisted of external singers and entertainment. A Frank Sinatra tribute act had been to the service two days prior to our inspection, people told us they had enjoyed this. One person told us: "There are lots of activities and entertainment provided with my favourite being the rock and roll singers". This person also told us that they went to church every Sunday and looked forward to it.

Some people accessed the community alone, going to the town and local amenities. The manager told us that they liked to involve the local community by bringing in outside entertainment and activities as much as possible. The provider had a minibus which we were informed was used for day trips in the summer months.

Staff knew people well and care was responsive to people's needs, however care records did not reflect people's current care needs, although they had been regularly reviewed. The manager and deputy manager assured us that people's care plans would be up dated. A relative told us: "I haven't been invited to formal review for [my relative] but the manager is always asking me if everything is okay and I am happy".

People told us they knew who to speak with if they had any complaints. One person told us: "If I had a problem I would speak to the county council or the providers, they are very good". Relatives we spoke with told us that they were kept informed and fully involved in the care of their loved ones and had no complaints about the care. One relative told us: "If I need something done it's done, I've never had a problem or had to complain".

Requires improvement

Is the service well-led?

Our findings

When people who used the service had been involved in an incident of suspected abuse it had not been referred to the local authority for investigation. The MCA and DoLS guidance had not been followed to ensure that people were safe and not being unlawfully restricted. This meant that the provider and manager were not working with other agencies to ensure a continuous improvement in the standard of care being delivered.

Systems were in place to seek people's views and experiences of the home. These included regular meetings and an annual survey. People had the opportunity to discuss and comment on a variety of issues, for example on the food, activities, the environment and the staff. However some people could have benefitted from a more varied choice of food for their vegetarian diet.

Regular audits and maintenance checks were undertaken to ensure that the service was monitored to maintain the quality of service and equipment. However systems were not in place to ensure that people received their prescribed food supplements in a timely manner.

People who used the service, their relatives and staff told us they liked and respected the management and felt supported. They said the management were welcoming and the service homely. One relative told us: "It's absolutely marvellous here, free and easy".

There was a new registered manager in post and the former manager was remaining at the service to support them for a period of time. The provider was present at the service regularly and people told us they felt free to be able to approach him at any time.

Staff told us they felt supported to fulfil their role through regular training and appraisals. There were regular staff meetings to ensure that staff were involved in the decision making within the service. One member of staff told us: "The manager is very approachable at any time". There was a clear line of responsibility; staff knew who to speak with if they required support.

All the staff we spoke with told us they knew how and would be supported if they needed to whistle blow about a colleague if they suspected abuse and they would be able to do so with no repercussions.

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 11 HSCA (RA) Regulations 2014 Need for consent **Care and treatment of service users must only be provided with the consent of the relevant person.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment must be provided in a safe way for service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The nutritional and hydration needs of service users must be met**