All About Care Limited

Wimbledon House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Wimbledon House Residential Care Home is a residential care home providing personal care to 29 people with mental health needs at the time of the inspection. Wimbledon House accommodates up to 34 people in one adapted building.

People's experience of using this service and what we found
The registered manager did not ensure auditing systems and process were established and operated effectively. There was a lack of oversight by the registered manager over the day to day running of the service. There was no effective system to record and analyse accidents and incidents to ensure any patterns or trends could be monitored, identified and acted on.

Risk assessments, such as the risk of choking, were not sufficiently detailed. For example, there was no guidance for staff about what to do should a person begin to choke, in line with good practice. Whilst staff, who knew people well, had been trained in first aid, the service was using agency staff and recruiting new staff. This meant there was a risk staff who were unfamiliar would not know what action to take.

When people were at risk of constipation, there was insufficient guidance for staff about when the medication should be given or when to seek advice from a health care professional. Other risk, such as a possible deterioration in mental health were in place.

People were protected from the risks of abuse, and discrimination. Staff understood how to report concerns. People were supported by a consistent staff team who had been recruited safely.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People told us they felt safe and happy living at the service. Equality and diversity were promoted by staff who treated people equally as individuals. People were encouraged to make suggestions about the day to day running of the service and their ideas were listened to and acted on.

People were supported to see health care professionals when needed. Staff worked closely with community psychiatric nurses, community nurses and GPs to make sure people received the support they needed.

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

Rating at last inspection
The last rating for this service was good (published March 2020).

Why we inspected
This inspection was prompted by a review of the information we held about this service.
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.
For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.
We have found evidence that the provider needs to make improvements. Please see the Well-led section of this report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified breaches in relation to good governance. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our safe findings below.

Wimbledon House Residential Care Home

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. We checked 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 1 inspector.

Service and service type
Wimbledon House Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under 1 contractual agreement dependent on their registration with us. Wimbledon House Residential Care Home is a care home without nursing care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with CQC to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people living at the service and 2 relatives. We spoke with 8 staff including the registered manager and general manager. We spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included 4 people's care plans, associated risk assessments and multiple medication records. We looked at 3 staff files in relation to recruitment, training and supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to 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

● Risks to people's health, safety and welfare were assessed. However, some risk assessments were not robust and did not include measures to be taken to reduce risks to people. When people were at risk of choking, there was guidance for staff about how to support the person. For example, ensuring they were provided with soft textured meals or had their food cut in small pieces. When a person required a member of staff to sit with them for additional support at mealtimes, we saw this support was provided. However, the risk assessment did not guide staff on what to do should a person begin to choke. Whilst staff, who knew people well, had been trained in first aid, the service was using agency staff and recruiting new staff. This meant there was a risk staff who were unfamiliar would not know what action to take. Following the inspection, the registered manager provided evidence these risk assessments had been individually updated to reflect actions needed should a person begin to choke, and confirmed staff had been spoken with regarding these changes.

● People's mental health was monitored, and staff had guidance about what signs may indicate a decline in mental health. Staff told us, "Some people may only show little changes, but others are bigger. We keep a close eye on everyone so we can contact the doctor or community psychiatric nurse when we need to" and, "A lot of people have lived here a long time, and their mental health is pretty stable. We look out for any changes in their behaviour so we can make sure they have the right support. We work closely with the mental health team." A relative commented, "Staff are good at making sure [our loved one's] mental health is closely monitored. Staff check on him all the time and work with him as an individual."

● When people lived with diabetes, there was guidance for staff about what each person's normal blood sugar levels were. There was guidance for staff about what action to take, should the person's blood sugar levels be higher or lower than normal. Stock of sweets / drinks was stored in the medicines room for use when required.

● When a person had a catheter, to help drain urine, there was information for staff about what signs to look for which may indicate a problem with the catheter. Staff completed training about how to support people with a catheter. Staff we spoke with understood what action they needed to take, and when to take it.

Learning lessons when things go wrong

● Accidents and incidents were recorded on the electronic system by staff. The registered manager did not keep a log of incidents and accidents, to enable them to identify any patterns or trends. During the inspection the general manager implemented a system to record and analyse this data. When there had been incidents, people had been referred to the necessary health care professionals for support.

● When staff had raised concerns with the general manager, these had been listened to and acted on. For example, staff had raised concerns about a lack of spare bedding. This was addressed and further stock

purchased. Staff were reminded where the spare bedding was located.

Using medicines safely

●.Some people were at risk of becoming constipated and were prescribed PRN medicines. There was a PRN protocol in place, however this did not contain enough information. For example, these did not include when the medication should be given. NICE guidance regarding the administration of 'when required' had not been followed. These protocols were updated during the inspection, following discussions with people's health care professionals.

● Medicines checks and audits were completed by senior staff. When a shortfall was identified, such as missing signatures on the medicine administration records, senior staff addressed this with the staff concerned. The registered manager was unable to provide evidence they had followed up to ensure action had been taken to improve recording.

● People received their medicines as prescribed. Medicines were stored and disposed of safely. Staff wore a 'do not disturb' tabard whilst administering medicines to help avoid interruptions. One person told us, "Staff make sure I have my medicines when I need them." A relative said, "[Our loved one] has all their medicines managed by the staff because they would not remember to take them otherwise. I am confident he gets his medicines when he should."

● Staff completed medicines management training and their competency was assessed to ensure they continued to follow best practice.

● Staff said, "I take supporting people with their medicines very seriously. It is exceptionally important they have their medicines on time" and "People are encouraged, where possible, to take their medicines with minimal support."

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risks of abuse, harm and discrimination.

● People told us they felt safe living at the service. One person told us, "I definitely feel happy and safe here. I do my own thing. I have a key to my room. It stops anyone else going into my room." A relative commented, "[Our loved one] is very safe at Wimbledon House. We visit regularly and the staff are very good."

● People were protected from the risks of financial abuse. People told us, "[The registered manager] looks after my money. When I want some, say to buy some cigarettes, I just come and ask for it". During the inspection, several people spoke with the registered manager about accessing their money. They were provided with cash when requested. Receipts were retained and a running balance of monies was kept with each person's money. These were locked away for safe keeping.

● Staff completed training about keeping people safe. Staff were able to recognise potential signs of abuse and knew how to report concerns. Staff felt confident the registered manager would take the appropriate action should they need to raise a concern. Staff said, "I think people are kept safe. If I had any concerns, I would talk to the manager straight away" and, "People are safe. I wouldn't think twice about contacting the local authority if I thought someone was unsafe."

Staffing and recruitment

● People were supported by a consistent staff team. The registered manager arranged for agency staff to cover shifts if needed. The same agency staff were used to ensure there was consistency and reduce anxiety for people living at the service. One member of staff told us, "We are always busy, but we work really well together. We manage to fit in taking people out which is great."

● People told us the staff were there to support them when they needed it. People said, "The support from staff is second to none. I get the help I need when I need it. There is always someone around if I need help with anything" and, "They are all kind. They help me when I need it. They are always around. If I need them; I know where they are. If I need it, they help me if I need to see a doctor."

● People were supported by staff who had been recruited safely.
● A full employment history was obtained and any gaps in employment were explored, explained and recorded.
● References, including one from the most recent employer, were obtained to make sure new staff were of good character and safe to work with people.
● Criminal record checks with the Disclosure and Barring Service (DBS) had been completed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

There were no visiting restrictions and people received visitors when they wanted to.

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 MCA 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 when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
● The registered manager submitted DoLS applications when required and checked to make sure whether there were any conditions relating to the authorisations.
● Staff completed training about mental capacity and DoLS to keep up to date with best practice.
● When people were unable to make specific decisions for themselves, the registered manager involved their relatives and health professionals to make sure decisions were made in people's best interest.

Requires Improvement

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There was a lack of oversight and scrutiny on the day to day running of the service by the registered manager. Systems and processes to assess, monitor and improve the service were not operated effectively. The registered manager did not record any quality assurance checks they completed. Records, such as supervisions and competency checks, were disorganised which made it difficult for the management team to monitor. The registered manager was unable to produce various essential records when we asked for them. Whilst accidents and incidents were recorded, there was no effective system to analyse them to ensure any patterns or trends could be monitored, identified and acted on.
- Senior staff completed checks and audits, such as medicines management and infection control. Whilst the senior staff followed up on any shortfalls with the staff team, the registered manager had not provided support with this. There was a lack of oversight of these, checks. The registered manager had not reviewed the senior staff audits to ensure the correct action had been taken, or, if needed, that performance management was implemented.
- The general manager completed regular audits and provided action plans when shortfalls were identified. However, the registered manager had not taken the requested action. For example, a general manager's audit was completed in August 2022, and reviewed with the registered manager to discuss the actions needed. One action was for safeguarding to be discussed at all staff meetings. Staff meeting minutes in September 2022 showed safeguarding had not been discussed. This meant staff had not been given the opportunity to learn from any safeguarding incident to improve practice. Following the inspection new monitoring processes were introduced by the general manager to ensure future action would be taken in a timely way. The general manager informed CQC they would be attending the service each day to provide additional support to the management team to drive the necessary improvements.

The registered manager failed to ensure systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff understood their roles and responsibilities. Senior staff led each shift and allocated tasks to staff to ensure people received the support when they needed it. Staff worked flexibly to support people. For example, a person requested to go out in the morning and staff allocations were amended to make sure there was a member of staff free to support them.
- The provider had governance systems in place to monitor the safety and quality of care at the service

which they had been informed had been completed, upon reviewing it was established that these had not and action was being taken to address this. The nominated individual completed regular visits to the service and monitored any environmental issues. For example, during one visit the nominated individual recognised there was a potential trip hazard with flooring in the lounge area and arranged for the maintenance team to resolve this.
● The service was undergoing refurbishment which included the installation of a lift. New carpets and repainting were due to be completed following the installation. The nominated individual monitored the timescales for completion of this work.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The management team understood their responsibilities in relation to duty of candour. This is a set of specific legal requirements that services must follow when things go wrong with care and treatment. The Care Quality Commission and local authority safeguarding team were informed of notifiable incidents, such as a serious injury or police involvement, in line with guidance.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Equality and diversity were actively promoted. People's protected characteristics, such as sexuality, religious beliefs and disability were considered to ensure people were treated with respect and equality. People were encouraged to share information about protected characteristics. Staff completed equality and diversity training to make sure they had the skills and knowledge to understand the Equality Act. A relative commented, "Staff provide for [our loved one] as an individual."
● Quality assurance questionnaires were completed by people and staff to help identify areas of strength and areas for improvement. Results of recent survey showed people felt they were treated equally, felt safe, and felt well supported by staff and management.
● There were regular resident meetings where people gave their views on the day to day running of the service. When people had made suggestions to make changes to the service, these had been listened to and acted on. For example, people had suggested additional options to be provided at mealtimes. New alternatives, such as jacket potatoes, lasagne and fish pie had been added to menus.
● Results from staff surveys were positive, with staff noting they felt supported by management and felt listened to. Comments included, 'Everyone at Wimbledon House cares about the residents; there are a lot of good staff', 'We all work together as a team' and, 'Higher management will always listen to concerns'.
● People knew the registered manager well and spoke positively about them. One person told us, "[The registered manager] is smashing, she is really good. I can go to her whenever I want to. She always has time for me." A relative commented, "[The manager and deputy manager] are very effective and very caring. They are very good at keeping us informed."

Working in partnership with others
● The management and staff worked with health care professionals, such as community psychiatric nurses, physiotherapist, community nurses and GPs to ensure people received additional support when it was needed. A relative commented, "[Our loved one] has reviews with the psychiatrist and we are invited to be there to offer additional support."
● People told us staff supported them to see health care professionals when they needed to. People said, "Staff support me to see the doctors and nurses and they are doing everything they can to help me" and, "If I need it, they help me if I need to see a doctor."
● A new room had recently been created to ensure people had a quiet space to meet with their health care

professionals.

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 17 HSCA RA Regulations 2014 Good governance The provider and registered manager failed to ensure systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of the service provided.