Wilton House Limited

Wilton House Residential and Nursing 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

Wilton House is a residential and nursing home providing personal and nursing care for up to 51 people. At the time of our inspection 43 people were living at the home. Wilton House accommodates up to 51 people across two floors, each of which have their own dining and living space. Individual bedrooms have an en-suite.

People's experience of using this service and what we found
Infection prevention control measures were poorly managed. Staff were not wearing personal protective equipment (PPE) in line with the guidelines. Where people were positive of COVID-19, measures were not in place to mitigate the risk of spreading the infection. This was addressed at the first inspection visit and improvements had not been made on the second visit.

The provider and registered manager had a governance system in place, which included various audits and monitoring. However, actions were not always documented, and it was unclear if actions were completed. In addition, immediate improvements in relation to infection prevention control were not actioned between inspection visits which posed a risk to people.

People had risk assessments in place, which detailed how to support them. People received their medicines when they needed them. However, records for medicines prescribed for when needed were not present which did not offer clear instruction as to when it was appropriate for the person to have this medicine. Staff received training to help ensure they were sufficiently skilled.

People and relatives felt staff provided care that was safe, and systems were in place to report concerns. The staff team had been safely recruited. Systems were in place to report and respond to accidents and incidents.

Staff felt morale was good and felt supported by their manager. The registered manager had built positive relationships with professionals and was dedicated in making sure people got input from health professionals when needed. The registered manager gave examples of where professional involvement benefited the people they supported.

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 24 December 2019)

Why we inspected
We undertook a targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about infection prevention control measures. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with infection prevention control, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe infection prevention control practice at this inspection.

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 well-led findings below.

Wilton House Residential and Nursing 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 included checking the provider was meeting COVID-19 vaccination requirements. 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
This inspection was completed by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Wilton House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was asked by CQC to complete a Provider Information Return (PIR) during this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection-
We spoke with three people who used the service and 10 relatives about their experience of the care provided. We spoke with seven members of staff including the registered manager, nurses and care workers. We reviewed a range of records. This included three people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

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 deteriorated 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.

Preventing and controlling infection

- We found where people were positive of COVID-19 the staff were not putting in safe measures when moving around the home or mitigating the risk to other people in the home. We observed staff not donning and doffing personal protective equipment (PPE) when leaving a room where a person was positive of COVID-19 and isolating, to a room where a person did not have COVID-19. This was fed back to the registered manager, however on the second visit we found that staff were continuing to not use safe practices when using PPE.
- People were not kept safe from exposure to the virus. We observed two people who were positive of COVID-19 sitting with other people living at Wilton House having dinner. There was no consideration on the impact of other people living there.

Infection prevention control measure were not robust and subsequently put people at risk of infection and systems had not mitigated the risks to the health, safety and welfare of people using the service. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider's infection prevention and control policy was up to date.
- The providers approach to visiting aligned to the government guidance. Relatives confirmed they were able to visit when they wanted to, however these were booked appointments to make sure the registered manager can ensure relevant checks could be made to ensure people were safe.
- We checked to make sure the service was meeting this requirement. We found the service had effective measures in place to make sure this requirement was being met.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency.

Using medicines safely

- We found there to be a lack of documentation for instructions to support the use of when required 'PRN' medicines. These were not always in the administration folder or up to date with people's individual support needs around this medicine. Without PRN protocols in place to support the use of these medicines we could not be confident assured that new staff would be able to understand when and how to use this medicine. When speaking with staff they were able to describe when the person needed the medicine.

● People received their regular medicines when they needed them by staff who were trained and competent to administer medicines.

Staffing and recruitment
● The registered manager completed a dependency tool which looked at how many staff were needed to support people. At the time of the inspection the home had an outbreak of people positive with COVID-19. We found there were a significant amount of people in their bedrooms who were isolating, however there were a number of people who were not isolating but still being supported in their bedrooms.
● Records and observations showed little interaction with people and staff as the staff were trying to manage individuals immediate support needs. The registered manager had not taken this situation into consideration when reviewing the dependency tool.
● People we spoke with said the staff were kind, however one person felt that the staff did not always have time to support them or listen to them. One person said, "I want to get out of bed for a little while to look outside the window. I asked the staff and they said they would come back, but they never did. Eventually when I asked again another staff member said it was 10pm and I was not allowed to get up."
● Relatives gave mixed views about the staffing ratio. One relative said, "I do think they could do with more staff. It is difficult to speak to anyone though to get updates. I called six times the other day to try and speak to someone about [relative]. They said someone would call me back, but they never did."
● There was a robust recruitment process in place, and this helped ensure only suitable staff were employed. At every interview there was a representative from a person living at Wilton House who was part of the interview and decision-making process.
● People were supported by staff who had been through pre-employment checks, such as references and a disclosure and barring service (DBS) check. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Learning lessons when things go wrong
● The registered manager did not identify safety concerns in relation to infection prevention control or address the improvements required quick enough. On the first inspection visit we found areas of improvement where staff were using poor infection prevention measures. We fed this back to the registered manager, however when we returned for the second visit, we continued to find the same areas of improvement.
● We found lessons had been shared in relation to other health and safety concerns that had been gathered from other providers and care homes.

Systems and processes to safeguard people from the risk of abuse
● The provider had systems in place to help ensure people were supported safely. The registered manager made sure there was a consistent approach to safeguarding matters, which included completing a detailed investigation and sharing the learning with staff following any incident.
● People were safe from abuse and staff understood how to protect people. The service and its staff team worked well with other agencies to do so.
● Relatives said they felt their family member was safe. One relative said, "No worries about safety whatsoever. They have been amazing and supported [relative] in every way. They hoist [relative] and the attention to detail is excellent. They talk to [relative], check how they are feeling, explain to us what they are doing, superb. They have put bed rails up for [relative] to keep them safe in bed."

Assessing risk, safety monitoring and management
● The registered manager ensured there was a proactive approach in managing people's individual risks

relating to their support. Staff felt they had the training which enabled them to manage situations in a positive way where people may become anxious

● People had call bells in the event of needing urgent assistance. We found that staff were responding to these in a timely manner.

● People's care records were accessible to staff, and it was easy for them to maintain quality clinical and care records.

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 requires improvement. The rating for this key question has remained 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; 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; Continuous learning and improving care

- The manager had quality assurance systems in place, however these systems were not always reliable and effective. For example, we found documentation such as, medicines records for as required medicines were not available. We found staff using poor infection prevention measures and although the registered manager fed this back to staff, there was no improvement following the second inspection visit.
- The management team did not consistently capture actions to introduce improvements. These were either not identified or lacked detail as to if these had been completed. The registered manager acknowledged this and spoke about steps they were taking to improve the quality audits and action plans.
- Lessons learnt were discussed with staff, however we found that the actions taken from the lessons learnt were not always implemented and the management team did not continue to actively challenge staff on this.
- The provider had regular contact with the registered manager and started to gain feedback from staff and people.
- The management team and staff understood their roles and respected the impact their roles had on people. The registered manager worked alongside the staff team routinely and assessed the delivery of care as part of their daily work.
- Staff felt the registered manager was supportive and approachable. One staff member said, "We are a team that works very hard to make this place people's homes." Another staff member said, "I wouldn't work anywhere else- we are like a family here- even the (registered) manager."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff reported the morale of the staff team was good and they were happy in their work. They acknowledged it had been a difficult time due to the pandemic, but staff have worked well together. One staff member said, "It's been a tough two years, but a lot of the staff have stayed which makes for good teamwork."
- Relatives gave a number of examples where the positive person-centred care their family member had received had a positive outcome on their health and well-being. For example, one relative said, "When [relative] first went there they were underweight and dehydrated. [Relative] wouldn't wash or take care of

themselves and generally unwell. They [staff] have looked after [relative] so well, [relative] is in a healthy weight range, drinks well and has been really well looked after. They keep a good eye on [relative] and can spot if they are under the weather."

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

● People, and those important to them, worked with managers and staff to develop and improve the service. The provider sought feedback from people and those important to them and used the feedback to develop the service. Staff engaged in local and national quality improvement activities.

● Relatives we spoke with said they were kept informed about the care people were receiving and that the home was managed well. One relative said, "[Registered manager] manages the home really well. It was difficult for [Registered manager] to start with but the interaction between [Registered manager] and the staff is excellent. [Registered manager] is very professional and approachable. [Registered manager] would phone us with updates during lockdown." Another relative said, "We get updates from [Registered manager] in emails. [Registered manager] gets the best out of the staff. There has been a big improvement since [Registered manager] has been there."

● Staff gave feedback through individual face to face meetings with the management team and surveys. Where improvements were highlighted, staff felt they were listened to. One staff member said, "The (registered) manager makes us feel that we are important, and I can always go to her if I have a problem."

Working in partnership with others

● The registered manager gave examples of how they had regular input from other organisations and health professionals. One professional gave feedback to the registered manager that, ' All care workers and staff members are highly motivated with people in mind, an example of this would be the person in charge of the medicines asking me if I could check the medicine times of their residents for interaction and best outcomes for their medicines with reference to their diet plans.' Another professional said, 'Registered manager always welcomes feedback and will implement any changes or improvements where a concern had been highlighted.'

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Infection prevention control measure were not robust and subsequently put people at risk of infection and systems had not mitigated the risks to the health, safety and welfare of people using the service.