Wimbledon Opco Limited

Signature at Wimbledon

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

This responsive inspection took place on 5 November 2018 and was unannounced.

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

Signature of Wimbledon is a large purpose-built building split over three floors, in the London Borough of Wimbledon, for up to 79 older people. At the time of the inspection there were 43 people using the service.

The service was previously known as Kingsmere Retirement Home, registered to provider Avery Homes (Wimbledon) Limited. This provider organisation was acquired by Signature and Kingsmere Retirement Home became Signature of Wimbledon in May 2018. The service was previously inspected in February 2018 and rated 'good' overall, however we rated the key question 'is this service effective?' as 'requires improvement' as staff were not always supported through appropriate training and supervision.

At the time of this inspection, in November 2018, there was not a registered manager in post. The manager had applied to the Commission to become registered. 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.

People were not protected against identified risks, as risk management plans were not always in place and staff did not always have up to date guidance to mitigate those risks. Incidents and accidents that took place at Signature of Wimbledon were not always clearly documented, reviewed and audited in such a way as to ensure lessons were learnt. We shared our concerns with the manager who sent us an updated action plan and copy of a completed risk management plan.

People's medicines were not always managed in line with good practice as PRN (as and when) medicines protocols were not always in place and dosages of medicines were not always recorded. The newly appointed manager had identified issues around safe medicines management and was implementing new systems to ensure improvements were made.

People received care and support from staff that had undergone robust pre-employment checks to ensure their suitability for the role. Staffing levels did not always afford staff ample time to develop meaningful relationships with people.

People were protected against the risk of abuse as staff knew how to identify, report and escalate suspected abuse. Staff confirmed they would be confident in whistleblowing should the manager not address suspected abuse in a timely manner.

The provider had adequate systems and processes in place to minimise the risk of cross contamination through effective infection control management.

Audits carried out by the service did not always identify issues in a timely manner and action taken to address these did not always take place swiftly. We raised our concerns with the manager who sent us an action plan to address our concerns.

People were not always aware of the management structure within the service and felt communication could be improved. People's views were sought, through regular house and relative meetings and comments boxes.

The manager sought partnership working with other healthcare professionals to drive improvements.

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 as safe as it could be. Risk management plans were not always in place to give staff guidance and keep people safe.

Incidents and accident forms were not always fully completed. Management did not always sign off the forms, meaning it is unclear if lessons were learnt.

People were protected against the risk of abuse as staff knew how to identify, report and escalate suspected abuse.

Medicines management was not in line with good practice. The manager was implementing strategies to improve the medicines management.

Although staffing levels were at safe, staff appeared hurried and unable to spend quality time with people to develop meaningful relationships.

The provider had adequate systems and processes in place to minimise the risk of cross contamination.

Is the service well-led?

Requires Improvement

The service was not as well-led as it could be. Audits did not always identify issues to ensure action was taken in a timely manner.

People were not always aware of the management structure within the service.

People's views were sought through comments boxes, regular meetings and discussions.

The manager sought partnership working to improve the provision of the service.

Signature at Wimbledon

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.

This inspection took place on 5 November 2018 and was unannounced. We undertook this focussed inspection to look at whether people were safe and whether the service was well-led due to the high number of medicines errors, falls and pressure sores reported by the service.

The inspection was carried out by two inspectors and two experts-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.

We reviewed the information we held about the service prior to the inspection, this included for example, information shared with us from members of the public and health care professionals. We also checked notifications made to us by the provider, safeguarding alerts raised regarding people living at the home and information we held on our database about the service and provider.

During the inspection we spoke with 11 people, five relatives, three care support workers, two music facilitators, the peripatetic manager, the manager and the area manager. We looked at four care plans, medicine administration records, accidents and incidents, safeguarding and other records relating to the management of the service.

After the inspection we contacted a healthcare professional to gather their view of the service.

Requires Improvement

Is the service safe?

Our findings

We reviewed people's medicine administration records (MAR) and found that stock balance checks were irregular, and did not always match the remainder or tablets stored. One person had a full box of Zoplicone tablets with their medicines, however this tablet was not prescribed on their MAR. There was a risk that this person or others could be given this medicine as it had not been disposed of correctly. The same person was prescribed a variable dosage medicine, and records showed that staff had signed to say the medicine had been administered. However, staff had not recorded how many tablets had been given to the person; nor was there a variable dosage record available for the medicine. We also found that PRN protocols were not consistently in place for people that needed them. There was a risk that staff would not always administer people's medicines correctly.

The provider had identified through a medicines audit that improvements were required to ensure that medicines were managed safely at all times. The provider's peripatetic manager had been placed at the home to support the learning of senior staff to improve their medicines administration skills. Medicines discussions were included in regular supervision sessions, and where staff made errors they were subject to multiple competency assessments until management were satisfied they were competent. A full audit of all medicine administration charts (MAR) had already commenced and the peripatetic manager told us that stock balance checks, staff signatures and protocols for 'as needed' (PRN) medicines had been identified as an area for improvement.

We found that medicines were stored appropriately in temperature controlled rooms, and observed the medicines trolley to be securely locked when staff were supporting people to receive their medicines. Staff had suitable medicines competency assessments in place to review their ability to administer medicines to people.

People were at risk of harm, as the provider had not ensured that sufficient risk assessments were always in place to support staff to protect people from potential harm. A staff member told us, "The risk assessments are to prevent incidents from happening and prevent future incidents or near misses." Notifications received prior to the inspection, and the home's incidents records, highlighted that some people living at the home had suffered multiple unwitnessed falls. However, we reviewed the risks assessments for four people and found that they did not have falls risk assessments in place. People's care plans contained minimal information on their mobility needs and preferences, but there was no suitable guidance in place for staff to guide them on how to help people to move around the home safely. We shared our concerns with the manager who after the inspection sent us confirmation that all falls risk assessments had now been completed and risk management plans updated. We were satisfied with the manager's response. We will review this at their next inspection.

We received mixed reviews about people's safety when living at Signature of Wimbledon. One person said, "I feel safe, generally the feeling is good." Another person said, "They [staff members] look after everything and they look after me very well. I feel very safe." However, a third person said, "I feel safe apart from when they [staff members] help me to walk or move from chair to chair. They rush me and I wobble and it makes me

rather anxious. I am partially deaf and don't always hear them if there are more than one of them."

Staff were aware of how to identify, report and escalate suspected abuse. One staff member told us, "You can see the change in the person if you know them. They may be depressed, may act out, may be withdrawn and stay in their room. The first thing I would do is report to a senior [staff member] and let them know, then document it. I would go above [the manager] and I would whistleblow, to safeguarding and [the Commission] if the manager didn't do anything." Staff confirmed they'd received safeguarding training and were confident the manager would act swiftly to any alleged abuse raised. Records confirmed what staff told us.

People who may display behaviour that others could interpret as challenging received support from some staff that had attended NAPPI training. NAPPI training is 'accredited managing challenging behaviour training, which emphasises positive behaviour support.' Staff confirmed they had received challenging behaviour training and this was also covered during their induction. However, there were times where they were concerned that people's behaviours placed both staff and other people at risk. We raised our concerns with the manager who confirmed there was on-going involvement with the local community behavioural team to monitor and implement strategies for reducing incidents of challenging behaviour. We were satisfied with the manager's response.

Incidents and accidents were recorded, detailing the nature of the incident, injury, action taken, lessons learnt and who has been notified. For example, medicines error, falls and instances of physical aggression. However, we identified records whereby various areas of the form had not been completed. For example, lessons learnt and management reviews had not been completed. We raised our concerns with the manager who informed us a new electronic recording system known as RADAR was now in use. RADAR is an electronic incident logging system, which allows information to be shared with key personnel to review and monitor trends. We were satisfied with the manager's response. We will review this at our next inspection.

The provider employed a full-time maintenance manager, who was new in post, and told us that a fire drill had not been conducted since July 2018 as it had been identified that staff required improved fire safety training. They told us that a drill was due to take place within the next two weeks. Records confirmed what the maintenance manager told us. We reviewed people's personal emergency evacuation plans (PEEPS) and found these to be generic. For example, one PEEP identified a person as requiring the use of a wheelchair to mobilise, however, there were no specific instructions for staff to follow in ensuring the person was supported to evacuate the service safely in the event of an emergency. We raised our concerns with the manager who told us, they were reviewing people's records and these would be updated shortly to reflect people's current needs. We will be reviewing this at our next inspection.

We received mixed reviews regarding staffing levels within Signature of Wimbledon. For example, one person told us, "There are usually enough of [staff members] to go around, you don't have to wait long and the young lady who cares for me is very nice and kind hearted. My problem is they rush and seem so busy, too busy to listen sometimes." Another person said, "They [staff members] are always available and always checking in on you so I think there are enough." However, a staff member told us, "Staffing levels have drastically improved as we now use agency. We have two regular agency staff. When they [agency staff] aren't regular, it makes it harder." We reviewed the staffing rota for three weeks and found there were gaps, these had been covered by agency staff, and meant that the service was operating within safe staffing levels. However, throughout the inspection staff appeared hurried and unable to spend time engaging people in meaningful conversation.

We reviewed the staff personnel files for four staff members and found these showed staff underwent pre-

employment checks prior to working at the service. Staff files included, for example, photographic identity, proof of address, satisfactory references and a Disclosure and Barring Services (DBS) check. DBS is a criminal records check employers carry out to make safer recruitment decisions.

Staff were aware of their responsibilities with regards to infection control management and confirmed they had access to an adequate supply of Personal Protective Equipment (PPE) to minimise the risk of cross contamination. One staff member told us, "We have gloves and aprons and have used shoe covers." We reviewed the provider's policy and found whilst this did refer to reporting procedures and hand washing guidance, this was in the previous provider organisation's name.

Requires Improvement

Is the service well-led?

Our findings

We received mixed feedback regarding the management of Signature of Wimbledon. One person told us, "I would like to see a manager and not someone from the operations team as they are not always here. I think when you get to talk to a manager it is reassuring and good practise." A second person said, "The new manager seems efficient and proactive and genuinely listened when we met." Relative's felt strongly that communication with management needed to improve for people with dementia as they themselves are unable to communicate any news. A relative told us, "Communication with [the manager] was weak and sparse and I'd like more as my [relative] is unable to do this." A second relative told us, "I do know who [the manager] is because I have been here every day this week and she is new so we were introduced. There have been a few [changes] recently which is concerning as communication hasn't been as good since the changeovers."

Staff also felt communication could be improved between management and staff. One staff member said, "To be honest I feel like what I've seen from [the manager] she will be good. But I think she should be better at communicating with us. I haven't interacted with her as much as I should, but with the deputy manager I can go to her if I have an issue." A second staff member said, "Both [the deputy manager and manager] are really quite new, when you make mistakes they'll support you and give you more training."

The home conducted a variety of quality assurance checks to review care delivery across the home. A recent food, drink and dietary care audit had identified that improved cutlery was required on the dementia floor and we saw that this had been actioned. However, we saw an audit of people's personal care plans that covered all the plans for people across the home. The audit did not specify the care files that had been checked, and the audit tool did not allow for specific issues to be recorded and addressed. Furthermore, the audit had not identified the issues we found in relation to the lack of timeliness in responding to the review of people's risk assessment and care files. We raised our concerns with the manager who informed us they would be reviewing this and updating their practice accordingly. We will review this at their next inspection.

We received mixed reviews regarding the provider seeking people's views to drive improvements. Comments included, for example, 'our opinions aren't sought,' and 'communications are haphazard'. Records confirmed the manager sought people's views through people and relatives house meetings and a comments box. Meetings covered for example, meals provided, activities, communication, care received and roles and responsibilities. Records confirmed planned monthly meeting dates had been scheduled and people and their relatives were invited to attend and share their views. The manager confirmed a quality assurance questionnaire would be sent to people, their relatives and healthcare professionals to further gather their views.

The manager was aware of their responsibilities to the CQC including the submission of notifications when significant events occurred.

The manager sought and encouraged partnership working to improve the service quality with other healthcare professionals. The manager was committed to improving the service and sent us an action plan

with details on how this would be achieved. Records reviewed identified where appropriate the manager sought guidance and support from healthcare professionals to improve the service quality.