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Winterbrook Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection of Winterbrook Nursing Home commenced on 20 July 2017 and was unannounced.

The inspection was prompted in part by concerns raised by the provider with the local authority safeguarding team relating to the alleged abuse of people living at the service. The concerns are subject to a criminal investigation and as a result this inspection did not examine the circumstances of the concerns. However, the information shared with CQC about the alleged abuse indicated potential concerns about people's safety. This inspection examined those concerns.

Winterbrook Nursing Home is a care home providing accommodation and nursing care for up to 41 people. On the day of the inspection there were 32 people using the service.

There was a registered manager in place at the time of the inspection. However, the registered manager was not present during the inspection. 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 was not present at the inspection.

The provider had taken prompt action when concerns were raised with them. However, we found there was a lack of effective management. Systems in place to monitor and improve the quality of the service had not identified the issues we found during the inspection.

A culture that did not treat people with dignity and respect had developed and people were not always treated in a kind and caring manner.

People were not always protected from abuse and improper treatment and were not confident to raise concerns.

Medicines were not always managed safely and risks to people were not always assessed and managed.

People were not protected from the risk of infection and equipment was not always maintained to ensure it was clean and safe to use. The environment was not always clean and there were no effective systems to monitor the cleanliness of the service.

The provider did not ensure people were supported by staff who were suitable to work with vulnerable adults. Records showed that appropriate recruitment checks and risk assessments were not always carried out. Staff were not supported through regular supervision and did not receive training in line with the provider's training guidance to ensure they had the skills and knowledge to meet people's needs. There were sufficient staff to meet people's needs.

People were not always supported to have the maximum control over their lives. The service did not always support people in line with the principles of the Mental Capacity Act 2005.

Care plans were not always accurate and did not provide guidance to staff to ensure people's needs were met.

People did not always feel confident to make a complaint. Where complaints were received they were not always responded to and managed effectively.

People were positive about the activities and enjoyed participating in group activities. People enjoyed the food and nutritional needs were met.

We identified nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking further action in relation to this provider and full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from abuse and improper treatment.

Medicines were not managed safely.

Risks to people were not always assessed and plans were not always in place to manage the risks.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always supported through supervision and did not receive training to ensure they had the skills and knowledge to meet people's needs.

People were not always supported in line with the principles of the Mental Capacity Act 2005.

People enjoyed the food and received food and drink to meet their dietary needs. .

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treat people in a kind and caring manner.

People were not treated with dignity and respect.

People were offered choices and explanations were given to help people make an informed choice.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not always accurate and up to date.

People did not always receive support to meet their needs.

Complaints were not managed and responded to effectively.

Is the service well-led?

Inadequate

The service was not well-led

Systems to ensure the provider had an oversight of the quality of the service were not effective.

There was a culture that did not respect the rights of people.

The management team were aware of the impact of the recent concerns on people and were committed to making the improvements needed.

Winterbrook Nursing 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.

This inspection took place on 20 and 27 July 2017 and was unannounced.

The inspection was prompted following concerns raised with CQC. These concerns are subject to a criminal investigation and as a result this inspection did not examine the circumstances of the specific concerns. However, the information shared with CQC indicated potential concerns about the protection of people from harm and abuse.

The inspection was carried out by three inspectors 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.

Prior to the inspection we looked at information we held about the service. This included notifications the provider had submitted to CQC. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we observed staff practices and completed a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who were not able to talk with us.

We spoke with 15 people using the service and nine relatives/visitors. We also spoke with the providers of the service, the operations director, the human resources and compliance manager, two nurses, three health care assistants, two activity coordinators, the chef, the maintenance person and a cleaner.

We looked at five people's care records, the medicine administration records for eight people, five staff files and other records relating to the management of the service.

Following the inspection we spoke with three social and healthcare professionals.

Inadequate

Is the service safe?

Our findings

People were not protected from abuse and improper treatment. We carried out this inspection due to safeguarding concerns raised with the local authority safeguarding team. The concerns were still being investigated at the time of our inspection and were subject to a criminal investigation.

We asked people if they felt safe living at Winterbrook Nursing Home. Although most people said they felt safe, comments made by people indicated they were not always protected from abuse or improper treatment. Comments included: "They [staff] are a bit sharp with their comments"; "You have to be wary of what you say and there are snippets of anger and swearing sometimes"; "They [staff] are often tired and snappy"; "I'm not frightened, I'm not worried but there is an underlying feeling that things are unsettled here"; "You have to be careful what you say in here" and "They are a bit sharp with their comments. I prefer to see a cheerful and positive side to life". One person described staff as "Too rough" and another that staff were "A bit harsh".

There had been accepted behaviours in place that impacted on people's dignity. For example, the registered manager had introduced 'protected mealtimes'. This had meant people were not allowed to be supported to use the toilet during mealtimes. We saw records of a meeting held with people that stated, "[Member of staff] explained that during lunch and supper we are unable to take people to the toilet as it is our protected time of day". Following the safeguarding concerns raised by the provider, a member of the management team had attended a meeting with people and advised them that they were now able to request support to use the toilet at any time.

The provider did not have effective systems in place to protect people from harm and improper treatment. Staff had completed training in safeguarding adults. Staff knew where to report concerns outside of the organisation. However, staff had not always felt confident to do this. Staff comments included: "There was a culture that prevented us going above [registered manager]" and "I would talk to my manager. If they tell me they will take action I have to trust them". Staff told us this had changed and they were now being encouraged to report to the operations director and human resources and compliance manager. One member of staff said, "I would report to [operations director] because they are encouraging us to do that now".

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not managed safely. Records relating to the administration of medicines did not always contain accurate up to date information and were not always fully completed. For example, one person's medicine administration record (MAR), contained a hand written entry. The entry contained no detail of the strength of the medicine, the dose of the medicine to be administered or the time and frequency the medicine should be administered to the person. There was no record of the quantity of the medicine prescribed and the entry was not signed by the member of staff recording the medicine. We could not be sure this person received their medicine as prescribed.

We found several gaps on MAR where staff had not signed to confirm that medicines had been administered. However, the medicine for the relevant dates was not in the monitored dosage system. We could not be sure people were receiving their medicines as prescribed.

Where people were prescribed transdermal patches, records relating to the application and removal of these were not fully completed and did not record where the patch had been positioned on the person's body. A transdermal patch is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medicine through the skin. We could not be sure people were receiving their medicines safely.

Where people were prescribed 'as required' (PRN) medicines there were not always protocols in place to guide staff as to when the medicine may be required. Recording of when PRN medicines were offered was not consistent. We could not be sure people were receiving their medicines when required.

Equipment was not always used in a safe way. For example, two people were being supported in bed and had bed rails in place. The bed rails were not being used in line with the Health and Safety Executive guidance for the use of bed rails in care homes. There was no risk assessment in place to assess whether the distance from the mattress to the top of the bed rail was safe. We could not be sure people were safe from rolling or falling over the top of the bed rail.

Risks relating to fire safety were not always assessed and managed. Weekly fire checks had not been consistently maintained. There was no record of fire drills being completed. Government guidance relating to the Regulatory Reform (Fire Safety) Order 2005 advises fire drills should be completed at least annually to test the effectiveness of emergency plans.

Personal emergency evacuation plans (PEEP) were not always up to date and fully completed. For example, there was a PEEP in place for one person who was no longer living at the home and one person's PEEP had not been reviewed and updated since 20 February 2015. This meant that essential information would not be immediately accessible in an emergency to ensure people were supported to safety.

Equipment was not always maintained to ensure the risk of infection was managed. For example, one person's bed rail bumpers were torn and stained. Another person had bed rails in place. The bed rails were wooden and were chipped.

Equipment was not always kept clean to prevent the risk of cross infection. For example, people did not always have hoist slings for their individual use. Hoist slings used for more than one person were stored in a store room on the ground floor. The slings were not stored tidily, were touching the floor and were not all clean. We spoke to a care worker who told us "Slings are washed twice a week. If they were wet [if a person had been incontinent] I would wash them. It is our routine". Following the inspection the provider sent records relating to the maintenance and care of medical equipment in the service. The records showed that hoist slings for individual people were washed twice a week. However, there was no record of the communal slings being washed.

There was a cleaning schedule which detailed how the cleanliness of the service would be maintained. For example, a full carpet clean was to be completed every six months or after a spillage. There was no record of the carpets being cleaned in communal areas. Carpets in the communal areas of the service were stained and dirty.

Records relating to the cleaning of the home were not always completed. For example, some records relating to the cleaning of the service had not been completed since the 10 July 2017. We could not be sure

people were protected from the risk of infection.

Where risks to people were identified there were not always risk assessments and plans in place to manage the risks. For example, one person's care plan identified the person could present behaviour that could be seen as challenging. There was no risk assessment identifying the risk associated with the person's behaviour and there was no plan to guide staff in how to support the person when they presented with this behaviour.

Another person's care record stated they were experiencing pain and had been seen by their G.P. The G.P recommended pressure relieving equipment. This recommendation was made on 21 June 2017. We asked a nurse about the pressure relieving equipment. The nurse told us, "We tried to get (equipment) [deputy manager] is ordering one". The skin integrity care plan had been reviewed on 21 June 2017 and there was no record of the area of concern or the equipment being required or ordered. Following the inspection we spoke to the deputy manager who told us the pressure relieving equipment was in place and the person was being supported to use it.

Where risks were assessed and identified we could not be sure people were receiving support to manage the risks. For example, one person's tissue viability care plan identified they remained in bed and were using a pressure mattress. The care plan stated, "Regular repositioning". We spoke to a nurse who told us, "[Person] is on four hourly turning". Records relating to the support the person received did not record that the person was supported to reposition and did not evidence the person was supported four hourly. One record for a 24 hour period had only two entries to show the person had received support. The daily records for the person on 15 and 16 July 2017 indicated the person had redness to areas of their skin. One member of staff supporting this person was not aware of any change to the person's skin condition. The staff member told us, "[Person] is on a pressure mattress and is checked/changed position four hourly. No sore or redness; skin is intact".

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

These concerns were raised with the provider and on the second day of the inspection the provider had taken action to address some of the concerns. For example, new beds and bed rail bumpers had been ordered.

The provider did not have effective recruitment systems in place. Providers are required to carry out checks to enable them to make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. Checks should include Disclosure and Barring Service checks (DBS). One member of staff's recruitment record showed they started working at the service on 5 January 2017. A note on the record stated, "Awaiting DBS. Posted 29 May 2017". We spoke to the human resources and compliance manager who told us the member of staff had a recent DBS from a previous employer when they started working at Winterbrook Nursing Home. There was no record of the DBS from the previous employer and there was no risk assessment to support the decision to allow the member of staff to commence work without applying for a DBS.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt there were enough staff. One person when asked about staffing levels told us, "Generally good". One person who remained in their room told us, "They always come" when using their call bell.

Staff told us that staffing levels were sufficient to meet people's needs. Staff comments included; "There's enough staff. We work well together and get things done" and "There are generally enough staff. They (management team) take it seriously staffing".

The service was using agency staff to cover a current reduction in permanent staff. The provider worked with one agency to ensure consistency for people using the service. One staff member told us, "We take them [agency staff] around the home and pair them with experienced staff to ensure they are not left on their own".

Requires Improvement

Is the service effective?

Our findings

People were not supported by staff who had access to regular training, supervision and support to ensure they had the skills and knowledge to meet people's needs.

Records showed that staff had not always received regular supervision in line with the provider's policy, which stated staff should receive at least three formal supervision sessions a year and attend three team meetings. Staff files contained some supervision records. However, one staff file had no record for supervision between 31 March 2011 and 18 July 2017. Another staff record had no supervision record since 20 April 2016.

Staff we spoke with had not received supervision in line with the provider's policy. Staff comments included; "I have not met with [deputy manager] this year. Every year we should have two or three supervisions" and "We do chats with the seniors and any training that comes up we're offered".

Staff did not always feel supported. One member of staff told us, "There was not a lot of support at the start, but it's changed now, different people are in charge. At the start the team leader, I didn't feel I could go to for help. She wouldn't listen and would talk over me. I was a bit scared of them so didn't want to go behind their back".

Staff told us they completed training which included: dementia care, end of life care, fire safety, safeguarding and food safety. However, training records showed that staff had not updated training in line with the provider's training guidance. For example, one member of staff had completed fire training on 20 July 2015. The provider guidance stated fire training should be completed annually. Another member of staff had completed safeguarding training on 5 April 2013. The provider guidance stated safeguarding training should be completed annually.

New staff completed an induction period linked to the Care Certificate. The Care Certificate is a set of standards that should be covered as part of induction training of new care workers. However, the records for one member of staff that had commenced employment in January 2017 showed they had only completed a workbook for standard one of the Care Certificate. The member of staff's record also included a 'record of experience' form and a training plan. Neither document was dated or signed by the assessor or the member of staff. We could not be sure staff were competent to carry out their roles.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported in line with the principles of the Mental Capacity Act 2005 (MCA). 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 Act 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.

Where people were assessed as lacking capacity to make a decision there was not always evidence of a best interest process being followed. For example, one person's care plan included a capacity assessment related to the person's capacity to consent to bed rails. The capacity assessment identified the person did not have capacity to consent. However there was no record of a best interest process being followed.

The provider had installed CCTV in communal areas of the home. There was no evidence that the provider had consulted effectively with people, relatives, visitors and staff when considering the installation of CCTV. Three relatives we spoke with told us they had not been consulted in relation to the installation of the CCTV.

We saw records of a 'clients and family' meeting on 29 April 2017 advising those present that the provider was 'looking into have CCTV put up in the hallway, lounge and kitchen'. Records relating to a second meeting with 'clients' on 31 May 2017 identified that some people had raised concerns about the installation of the CCTV. The record stated people were 'not happy about having it up everywhere about the home as they feel they have no privacy and they thought this [Winterbrook Nursing Home] was their home'. Prior to the inspection we raised these concerns with the operations director. The deputy manager responded and advised us that they had spoken to two people and two relatives about their concerns. The deputy manager also advised that posters had been displayed prior to the introduction of the CCTV advising them of the date it would be installed.

The provider had no record relating to consideration of people who lacked capacity to be consulted in relation to the installation of CCTV and no record of a best interest process to make the decision for those people who lacked capacity.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were complimentary about the food in the service. People's comments included; "The food here is excellent" and "The food here is really good. I like chicken curry. I think they do a really good job with the food when cooking for lots of people with different tastes". There were choices available for every meal and people told us if they didn't like what was on offer the chef would make them an alternative. The chef was knowledgeable about people's dietary needs, likes and dislikes. The chef and assistant chef visited people regularly to ensure they were happy with the menus and the quality of the food. The chef told us, "[Assistant chef] goes round and does the menu choices (with people) every day. If people don't like the options they can ask for something else".

At lunchtime we saw most people enjoyed the food and ate well. Where people had specific dietary requirements we saw people received food and drink to meet their needs and were supported by staff in line with their care plan.

People's care records showed that people had access to health care professionals when their health condition changed. We saw that people had been referred to Care Home Support Services (CHSS), Speech and Language Therapy (SALT), podiatrist and G.P.

Requires Improvement

Is the service caring?

Our findings

People told us staff were not always kind and caring. People's comments included, "The answer usually is "We're too busy", "Sometimes they don't want to know" and "They often forget and don't do what you ask".

People were not always treated with dignity and respect by staff. Three staff referred to people who required support to eat and drink as "Feeds". For example one member of staff told us, "We do the feeds in their rooms first". A member of staff also told us the people eating in one dining room were, "The messy eaters".

People were not always spoken to in a kind and caring manner. For example, one person said to a member of staff, "You are late today". The comment was made in a light manner. The member of staff responded in a short, unfriendly manner by saying, "Don't be so rude". Another person asked a member of staff if they were working in the kitchen as they preferred the way they prepared a particular food item. The member of staff responded in a sharp and unfriendly manner. Saying "No" and walked away.

People's needs were not always met in a way that protected their dignity. For example, one person asked a care worker to assist them with an element of their personal care that required immediate attention. The care worker said to the person, "I'll get the hoist and I'll be back". The member of staff did not return. 20 minutes later a nurse asked the person if they needed anything. The person explained they were waiting for the care worker. The nurse told the person, "I can see her coming she's just having a little difficulty with the hoist". We saw the care worker was not approaching the person's room. The nurse then found the care worker and asked her to go and assist the person.

Another person asked care staff on three occasions for assistance. The three staff did not respond to the person's requests and the person was ignored.

People's privacy was not always respected. The monitors related to the CCTV were openly on display in the main office. When inspectors arrived we were shown in to the office where we were able to see people in corridors and sat at tables in the main dining area. The office was not locked and visitors could enter the office. This meant people's privacy was compromised. There was no evidence of a privacy impact assessment being completed in relation to the installation of the CCTV to assist the provider in identifying any privacy issues.

Following the inspection the provider told us they had turned off the CCTV monitor "Whilst we review our use of CCTV to ensure compliance".

This was breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some caring interactions where people were shown kindness and understanding by staff supporting them. For example, one person was supported to eat their meal. The member of staff took time to ensure the person was comfortable and explained what they were going to do before supporting the person to sit

up. The member of staff spoke with the person throughout the meal, encouraging them to eat and checking they were enjoying the food. When the person had finished eating, the member of staff touched them gently on the arm, asking if they would like a drink. The interaction clearly had a positive impact on the person.

People were involved in decisions about their care and staff offered explanations about the support being offered. For example, one person was unsure about taking their medicines. The nurse took time to explain to the person what the medicines were for and specifically that one medicine would ease their pain. The nurse checked with the person that they understood the explanation and asked if they were happy to take their medicine. The person happily took their medicine.

Requires Improvement

Is the service responsive?

Our findings

People told us staff did not always provide care as requested. One person told us, "It annoys me and I get a bit fed up when they are late in putting me to bed before 11pm.They are often late". On the day of the inspection one person told us staff had been "Very late" when supporting them to get up. The person asked the member of staff why they were late and was told by the care worker, "The Inspectors have come in and we have to do other things".

People did not always receive care to meet their needs. For example, one person had been assessed by a health professional in March 2017. The health professional advised that the current moving and handling method being used to support the person was not safe and the person required an additional piece of equipment to enable them to be supported safely and in line with their wishes. The health professional told us they had been advised the piece of equipment would be purchased. The person was reviewed by the health professional on 24 July 2017 and the equipment was not available. This meant the person was not being supported in a person centred way and their needs were not being met. Following the inspection we were advised the equipment had been ordered.

People did not always receive support in line with guidance from health professionals. For example, one person had been assessed by a speech and language therapist (SALT). The SALT assessment dated December 2016 stated, "Diet puree. Fluids stage one, syrup. If unwell thicken to stage two as a temporary measure. If increased concerns or not tolerating stage one then contact speech therapy. Only thicken to stage two if really needed". The person's care plan stated "Requires drinks thickened to stage one-two. Assess daily". A review of the care plan on 28 December 2016 stated, "Drinks thickened to stage two". We spoke to a member of staff who told us, "[Person] has custard (Stage two) thickness".

Another person had been assessed by a health professional regarding the use of a wheelchair. The health professional had provided detailed guidance on the positioning of the person when in the wheelchair. The entry in the person's care plan made by the health professional on 24 July 2017 stated "Was sitting upright. I advised staff to keep the chair in tilt. I adjusted the chair and made [person] comfortable". The health professional told us they had visited the service again on 27 July 2017 and the person was not tilted in their chair. The person's care plan also stated the person required a cushion under their arm to prevent them leaning. On the second day of the inspection we saw the person did not have a cushion under their arm. We spoke with a nurse who told us they would go and fetch a cushion.

People's needs were not always assessed and there was not always a care plan in place to guide staff in the support people needed. One person had moved into the home on 7 July 2017. There was no assessment prior to or following admission and there was no care plan in place.

This was breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care records were not always up to date. One person's care plan gave guidance to staff that the

person liked to be washed when out of bed. However, a review carried out on 30 May 2017 stated the person was not safe to sit on a commode so required a weekly bed bath. Another person's care plan stated they liked to have breakfast in the dining room. However, a review in May 2017 stated the person was "Staying in bed". The care plan had not been updated. We visited the person and found they were cared for in bed.

Care plans did not always contain accurate information. One person required positioning in their wheelchair. The care plan stated 'See photograph'. There was no photograph in the care plan or in the person's room. We spoke with a nurse who told us a health professional had visited and taken the photograph and would be providing a new photograph. We spoke with the health professional who told us they had not removed the photograph and had not been asked to provide an up to date photograph.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaints policy and procedure in place. However, people did not always feel confident to raise concerns. One person told us, "Don't feel confident to ask the manager".

We found that complaints were not always dealt with effectively. For example, one person's care plan included a record of the person making a complaint about neglect. The record also stated, "Validated [person's] complaint". There was no complaint recorded in the complaints book and no record of any action taken. Records of a meeting held on 26 July 2017 with some people living in the service included a concern raised about staff being rude. There was no record of this complaint in the complaints book and no evidence of any action being taken as a result.

Complaints records did not always include evidence of investigations that had taken place and the complaints log did not record what action had been taken to resolve the complaint. For example, a verbal complaint had been received from a visiting health professional. The complaints log was marked as resolved. We asked one of the management team about the complaint. They told us this complaint was being dealt with at the time of the inspection. The member of the management team told us the complaint had not been responded to appropriately when it had been received and had not been resolved.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were two activity co-ordinators employed to organise and deliver activities for people. Activities included: seated exercise; bingo; quizzes; reminiscence; flower arranging and cooking. The activity coordinator told us "When people first come in (to Winterbrook Nursing Home) we complete a get to know you booklet with families. It identifies hobbies and life histories". This informed the activities people might enjoy". For example, one person had enjoyed knitting. The activity coordinator had set up a knitting session and although the person could no longer knit, they enjoyed watching. People who preferred to remain in their rooms were visited by the activity coordinators who spent time chatting with them.

Regular outings were arranged to local garden centres and pub lunches. There was an attractive garden which people were able to enjoy. One person told us they enjoyed the garden. However, the person told us staff did not always have time to take people out. One member of staff told us, "There aren't individual trips out but we organise group trips out".

Inadequate

Is the service well-led?

Our findings

We carried out this inspection as result of safeguarding concerns raised by the provider with the local safeguarding team. The provider took prompt action and the staff implicated in the concerns were no longer working at Winterbrook Nursing Home at the time of the inspection.

However, during the inspection we found a number of concerns. The provider had not identified the concerns we found because they did not have effective systems in place to ensure they had oversight of the quality of the service.

A culture that permitted bullying and harassment had developed in the service. Staff comments about the culture of the service included: "It was awful here before, glad they've [staff who no longer work at the service] gone, it is so much nicer now"; "The culture is changing. Staff and residents are much happier" and "There's not that feeling now of being told off and shouted at".

The management team told us they had visited the service regularly. However, they had been unaware of the culture that had developed and the concerns relating to abuse.

Since the safeguarding concerns had been raised the management team had spent a significant amount of time in the service. However, they had not identified the issues we found during the inspection in relation to the culture and staff approach to people that did not always respect their dignity.

There was a whistleblowing policy and procedure in place, however it was not effective. The policy did not include contact details of the management team and staff did not feel confident to go outside of the organisation. The provider did not have systems in place to ensure the whistleblowing policy was understood by staff and to monitor staff concerns.

There was no system to monitor staff training and staff supervision to ensure staff were supported and had the skills and knowledge to meet people's needs.

There was no system to monitor and analyse accidents and incidents. Accident and incident records did not contain any information relating to action taken as a result of an incident in order to identify ways of minimising the risk of a reoccurrence.

Where systems were in place they were not always effective and had not identified the issues found. For example, to the infection control audits had not identified the concerns we found in relation to infection control. An audit of medicine administration records completed on 22 June 2017 had not identified any of the issues found during the inspection. A care plan audit had identified issues relating to care plans not being up to date. We saw this was discussed at a nurses meeting on 14 March 2017. The record of the meeting stated, "Ensure that care plans are updated and current". The meeting record also stated that care plan audits would be completed monthly. There was no record of any care plan audits since March 2017.

A quality visit had been completed by a member of the management team on 20 June 2016. The quality audit had identified areas for improvement. However, there had been no follow up to ensure that action had been taken to address the areas of concern.

Systems in place to gain feedback about the service were not effective. A quality assurance questionnaire had been sent out in April 2017. There was no outcome from the survey and no system to identify any actions needed as a result of the survey.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We told the management team of the concerns we had found during the inspection and they took action to address some immediately. For example, they ordered new beds and bed rail bumpers for those people who required them.

There was a commitment from the management team to take any action necessary to address the poor quality of the service. One member of the management team told us, "It's not about loyalty to [provider], it's not about loyalty to the company, it's about the residents. They must come first". The provider was confident they could take prompt action to resolve the issues found and told us, "That is our shortcoming. There shouldn't be an external organisation to come in and identify this. We should have a system in place and we will".

The management team recognised the impact the recent situation had on people, relatives and staff. The provider had sent out a letter to all relatives advising them of the on-going investigation and encouraging them to contact the management team if they had any questions or concerns.

The human resources and quality assurance manager was based at Winterbrook Nursing Home to monitor the service and drive the improvements needed. We saw them spending time with people and relatives and supporting staff. The provider told us that the management team would have a greater presence in the home to support everyone through the difficult period.

Staff were positive about the support they received from the management team. Staff comments included: "The management (Provider, operations director and human resources and quality assurance manager) are good when they come" and "[Provider] is very supportive. I couldn't ask for anyone better".

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Checks were not always carried out to ensure staff were suitable to work with vulnerable people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not supported through regular supervision. Staff did not have sufficient training to ensure they had the skills and knowledge to meet people's needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive care and treatment to meet their needs.

The enforcement action we took:

Notice of Decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect.

The enforcement action we took:

Notice of Decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not always consulted in relation to their care.

The enforcement action we took:

Notice of Decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive care and treatment in a safe way. Risks associated with infection control were not managed. Medicines were not managed safely.

The enforcement action we took:

Notice of decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 13 HSCA RA Regulations 2014

personal care	Safeguarding service users from abuse and improper treatment People were not always protected from harm and improper treatment.

The enforcement action we took:

Notice of Decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not responded to in an effective way. People were not confident to raise concerns.

The enforcement action we took:

Notice of Decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor and improve the service were not effective. Records were not always accurate and up to date

The enforcement action we took:

Notice of Decision to restrict admissions.