The Manor at Merton Ltd

Winterbrook Nursing Home

Inspection report

18 Winterbrook
Wallingford
OX10 9EF

Tel: 01491833922
Website: www.excellentcarehomes.co.uk

Date of inspection visit:
09 May 2019

Date of publication:
05 June 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Winterbrook Nursing Home is a care home that was providing personal and nursing care to 23 people aged 65 and over at the time of the inspection. The service can support up to 41 people.

People's experience of using this service:
People were not safe because risks to their health and wellbeing were not being managed effectively.
The provider did not have systems in place to ensure people were protected following accidents and incidents.
People were at risk of not receiving medicines as prescribed because medicines were not always managed safely.
The provider did not have effective systems in place to monitor and improve the service.
People were protected from the risks of infection by effective infection control systems.
Staff were supported by the manager and methods of communication had improved.
People were supported by a manager who was committed to improving the service and providing person-centred care.

Rating at last inspection: Requires Improvement. Inspection report published 26 January 2019.

Why we inspected:
This inspection was prompted by concerns and a serious incident. We examined how risks were assessed and managed which were areas concern.

Enforcement :
Please see the 'action we have told the provider to take' section towards the end of the report.

Follow up:
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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.

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.

Winterbrook 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notification of an incident following which a person using the service sustained an injury. The information shared with CQC about the incident and additional information received from the local authority indicated potential concerns about the management of risks. This inspection examined how risks were being assessed and managed.

Inspection team:
The inspection was carried out by one inspector.

Service and service type:
Winterbrook Nursing Home 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.

At the time of the inspection there was no registered manager in post. However, there was a new manager who was applying to register with CQC. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

What we did:
Prior to the inspection we looked at information we held about the service. This included previous inspection reports and statutory notifications. Notifications are specific events the provider must notify CQC about by law.

During the inspection we spoke with two people and one visiting health professional. We spoke with the manager, two nurses and two members of the care team.

We looked at three people's care records, medicine administration records for all people living in the service, two staff files and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

At our inspection in December 2018 safe was rated requires improvement. We found that risks were not always managed effectively. Risk assessments and care plans were not regularly reviewed and updated. At this inspection we found that these issues had not been addressed and the provider was not meeting the regulations.

We looked at this area in relation to the concerns which in part was the reason for this inspection

• Risks to people were not always managed effectively. One person was at high risk of pressure damage and had previously sustained pressure damage. The care plan detailed the steps to be taken to mitigate the risks to the person, however records showed these were not being followed.
• Systems for monitoring risks to people were not always effective. Where people required regular checks to ensure their safety and well-being, an "Intentional well rounding checklist" form was in place. However, the forms were not always completed in line with care plans. A nurse told us the forms should be signed at the end of each day by the nurse in charge to provide an overview of the support a person had received. None of the forms we looked at had been signed by a nurse.
• Staff did not always review and update care plans and risk assessments when people had experienced accidents and incidents, to protect people from future harm. The accident record book identified one person had experienced four falls in 2019. A review of the falls care plan following the first fall stated, 'No falls so far'. A review of the falls risk assessment following the second fall stated, 'No falls reported'. The falls log in the person's file had no recorded falls for 2019. There had been no steps taken to consider actions to mitigate the risk of further falls.

Using medicines safely
• Medicines were not always managed safely. Care plans relating to the administration of medicines were not always followed. For example, one person had a specific care plan to ensure medicines were administered to effectively manage their condition. The care plan stated that the time the medicine was administered should be recorded on the medicines administration records (MAR). The time was not recorded on the MAR.
• Records relating to the administration of medicines were not always fully and accurately completed. For example, one person was prescribed medicine to be administered three times a day. The MAR had been signed four times a day for five days. As the medicine was dispensed from the pharmacy in a monitored dosage system (MDS) it was not possible to administer the medicine four times a day. This error had not been identified by the nurses administering the medicines.
• Where people were prescribed 'as required' (PRN) medicines there were not always protocols in place to

guide staff when the medicines should be administered.

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

Learning lessons when things go wrong
• The provider did not have an effective system to monitor accidents and incidents. The manager had started to complete a clinical governance report which was to be submitted to the provider monthly. The report included accidents and incidents. However, not all accidents that had occurred throughout April were recorded on the report. The report did not contain sufficient detail about accidents and incidents to enable the provider to look for trends and patterns or for lessons to be learnt.

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

Staffing and recruitment
• There were sufficient staff to meet people's needs. One person told us, "They are very good at checking on me." During the inspection staff spent time sitting with people and responded promptly to request for support.
• Staff told us there were more permanent staff and there were sufficient staff to meet people's needs. One member of staff said, "Staffing levels are really good". Another member of staff said, "We still use some agency but they are the same ones".
• The provider had safe recruitment processes in place. Checks were completed prior to staff commencing work. Checks included references and a Disclosure and Barring Service (DBS) check which supported the provider to make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
• Staff had a clear understanding of their responsibilities to identify and report concerns related to harm and abuse. One member of staff told us, "I would report to the senior carers, the nurses and then the manager. I could ring Oxfordshire (safeguarding team), ring them and explain your concerns. The number is in the staff room." At the time of the inspection some staff were attending safeguarding training to ensure their skills and knowledge were up to date.
• The manager was introducing systems to identify and investigate concerns and had an understanding of their responsibility to report to external agencies.
• On the day of the inspection the manager was carrying out aspects of the investigation regarding the safeguarding incident that had prompted our inspection.

Preventing and controlling infection
• All areas of the service were clean with no malodours. The housekeeping team were proactive in responding to any areas where cleanliness was raised as a concern.
• Staff understood their responsibilities in relation to infection control and used personal protective equipment appropriately.

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

RI:□Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our inspection in December 2018 well-led was rated requires improvement. Systems to monitor and improve the service were not effective. At this inspection we found systems had not improved and the provider was not meeting the regulations.

• There was no registered manager in post. There was a manager in post who had been responsible for the management of the service for the six weeks prior to our inspection taking place. The manager understood their responsibilities in relation to monitoring and improving the service to ensure regulatory requirements were met. However, at the time of the inspection systems for monitoring the quality of the service were not effective.
• There was a new clinical lead appointed to the service who had introduced a range of audits. However, the audits had not identified the issues we found during the inspection. For example, a care plan audit had identified some issues in one of the care plans we looked at and these issues had been addressed. The audit had not identified the concerns found relating to the management of risks associated with pressure damage.
• The manager had started to complete the provider's monthly governance report. However, the report did not contain sufficient information to enable the manager and provider to have clear oversight of the service.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

• The manager was aware of the improvements required in the service and was open and honest about the difficulties they faced. They told us, "There is a need for a culture change". The manager spoke passionately about their vision for the future to ensure people received person-centred high-quality care. The manager had introduced some changes to improve people's experience. For example, the manager had reviewed the timings between meals and the time for lunch had changed to ensure people received food and drink at more appropriate intervals throughout the day. The manager had also introduced a 'resident of the day' programme which had started on 1 May 2019. This was to ensure people were regularly reviewed and

consulted about all aspects of their care.
• The provider and manager understood their responsibilities relating to duty of candour. For example, the provide had met with the relatives related to the incident which in part prompted our inspection.
• Staff had confidence in the new manager and felt changes being made were positive. One member of staff told us, "It's the best it's been in a long time".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The manager had improved communication with people, relatives and staff. They held a relatives meeting and staff meeting to introduce themselves and speak about their vision for the service.
• The manager also held daily meetings with the heads of all departments. The meeting enabled a discussion regarding the day ahead and to resolve any issues. There were weekly heads of department meetings to regularly review progress the service was making. During the inspection we observed the daily meeting. Staff were encouraged to engage in the meeting and the manager welcomed comments and feedback.
• Staff were positive about the manager's improvements in communication. One member of staff told us, "[Manager] straight away had a team meeting. She is trying to listen to the care staff. I find her approachable".

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 People were not protected from risks associated with their care and support. Medicines were not managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor and improve the service were not effective.