Blagreaves Care Home Limited

Windsor Park Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Windsor Park Nursing Home is a care home registered to provide personal care for up to 19 people who have nursing care needs, including people living with dementia. At the time of our inspection, there were 14 people living at the service. Accommodation was provided over two floors and a passenger lift was available.

People's experience of using this service and what we found
People were at risk of harm. Risks associated with people's care and treatment needs, including how clinical needs were assessed, monitored and managed were of significant concern. Guidance for staff about how to meet people's individual care and treatment needs either lacked detail or was not available for staff.

Clinical leadership and oversight at the service was insufficient as a result of both the registered manager and clinical lead being away from the service for prolonged periods due to the Covid-19 pandemic. The new director of the provider company and nominated individual had only recently taken over management of the service. There was some evidence of clinical supervision and competency assessments of nursing staff, however, these were not always documented sufficiently. This impacted on people receiving safe care and treatment.

There were no systems or processes in place to review incidents or any analysis completed that may have identified any themes or patterns to reduce reoccurrence. A failure to take action to learn from incidents impacted on people's safety.

People's dependency needs had not been assessed since 2019. This meant it was difficult to establish if staffing levels were sufficient to meet people's individual needs and safety.

Staff lacked specific training in some areas, impacting on people's care needs being fully known, understood or effectively met by staff at the service. Safe staff recruitment and induction procedures had not always been completed, exposing people to potential harm.

The procedures for staff to exchange information about people's care and treatment needs was not safe or effective.

The environment, including furnishings were worn and needing redecoration and refurbishment. The Provider identified this issue within their action plan and planned to refurbish the home within the next six - twelve months. Infection prevention and control procedures reflected the Covid-19 pandemic guidance. People received their prescribed medicines when they needed them.

Systems and processes to assess and monitor quality including health and safety had not been fully kept up to date. This included audits and checks in relation to medicines, care plans and risk assessments.

Following the inspection, the provider sent us an action plan based upon the main issues found at this inspection. The impact of the planned actions will be assessed at our next inspection.

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 28 December 2018). The rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

Why we inspected
We received concerns in relation to the management, oversight and governance of the service, including staffing and clinical competency. Many of these issues had occurred as a result of the Covid-19 pandemic. We raised these concerns pre-inspection with the provider, but were not sufficiently assured. As a result, we undertook a focused inspection to review the key questions of 'Safe' and 'Well-led' only

We received concerns in relation to the management, oversight and governance of the service, including staffing and clinical competency. We raised these concerns pre-inspection with the provider, but were not sufficiently assured. As a result, we undertook a focused inspection to review the key questions of 'Safe' and 'Well-led' only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them.

We have found evidence that the provider needs to make improvements. Please see the Safe, and Well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this report.

Enforcement
We have identified two breaches in relation to safe care and treatment and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the 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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Windsor Park 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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and two assistant inspectors. Two inspectors carried out a site visit, whilst two assistant inspectors made telephone calls with relatives and staff.

Service and service type
Windsor Park Nursing Home 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. Prior to entering the location we assessed risks associated with Covid-19.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. This included any notifications we had received from the service (events which happened in the service that the provider is required to tell us about). We reviewed the last inspection report. We also sought feedback from the local

authority and local clinical commissioning group. We used all of this information to plan our inspection.

During the inspection we spoke with eight relatives or friends of people who used the service about their experience of the care provided. We also spent time with people who used the service and observed the support they received. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with eight members of staff and the registered manager, deputy manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included in part, eight people's care records. We looked at four staff files. We reviewed a variety of records relating to the management of the service, including accidents and incidents, six people's medicine records, audits, and checks on health and safety.

After the inspection we continued to seek clarification from the provider to validate evidence found. This included but was not limited to the provider's current action plan, training data, policies and procedures and meeting records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Clinical care needs were not effectively assessed, monitored or reviewed and exposed people to the risk of harm.
- One person had not had their catheter changed as often as required and documented in their care plan and risk assessment. The catheter change was over-due by 17 days. The registered manager was unable to advise why this delay had occurred. This put the person at increased risk of a urinary track infection which could cause harm.
- A person's care records showed they had lost a significant amount of weight within eight months. The registered manger was unable to explain this weight loss and no referral to health care professionals had been made. The provider advised that again this was due to staffing issues at the home due to Covid-19. A dietician referral has since been made for this service user, however, the dietician has confirmed that their weight loss does not meet the criteria for a referral and no further action has been taken.
- People's nutritional needs were not effectively monitored. Some people had been assessed as requiring their food and fluids to be recorded daily. However, there was no evidence these records were monitored to ensure people were eating and drinking sufficiently.
- Concerns were found in the care and treatment of wounds. Two people had dressings to wounds. However, there was no care plan or risk assessment to provide staff with guidance about what dressing was required, how to clean the wound and the frequency of dressing changes. The impact of staff not having this guidance, exposed these people to further harm.

Learning lessons when things go wrong

- The system and process to review incidents, to analyse these and consider actions required to reduce further reoccurrence was ineffective.
- The incident record book contained 17 incidents that had not been reviewed. Some people had received multiple incidents such as falls. There was no evidence of action taken such as reviewing mobility care plans and moving and handling risk assessments. Additionally, referrals had not been made to external health care professionals such as the community falls team.
- There was no evidence of follow up and monitoring of people's health and well-being post incident. This lack of analysis, action and follow up, exposed people to further harm.

Staffing and recruitment

- Concerns were identified with the competency of nurse's clinical skills and the supervision, training and clinical leadership they received. There was insufficient evidence to show nursing staff received regular clinical supervision and competency assessments. Ongoing clinical supervision is a requirement to ensure competence is maintained.

● Nursing staff had not received training required to meet people's clinical needs. For example, nurses had not received syringe driver training. This is essential in providing end of life care. Nursing staff had relied on external health care professionals to provide this care intervention. This failure to ensure nursing staff were appropriately trained exposed people to the risk of harm as it meant their needs may not be met in a timely manner.
● Some nursing staff were not confident or knowledgeable in catheter, sepsis and diabetes care. The registered manager told us they were unsure how to change a catheter, because they 'were out of practice'. This was a concern as they were the nurse in charge providing clinical care. A nurse spoken with, demonstrated a limited understanding of sepsis and diabetes care.
● People's dependency needs had not been assessed since 2019. This information determined what staffing levels were required to meet people's individual needs and safety. The registered manager told us people's care needs had increased and they needed to review staffing levels.
● A relative told us they had some concerns about staffing levels. They said, "[Name] needs help getting up sometimes, they try and get up, but there is no one there and they have fallen a couple of times."
● Some staff raised concerns about staffing levels. One staff said, "We need one extra staff, so we could provide the extra, so we aren't running around."
● The provider had not consistently followed safe recruitment procedures. For example, agency staff were used to cover staff shortfalls. However, profiles relating to agency staff such as details of their training, criminal checks and identity were not available. This information is important for providers to assure themselves agency staff are competent and are safe to provide care.
● One nurse who commenced in July 2020 had started work before references had been obtained. Their application form was brought in during our inspection. Whilst the registered manager told us the nurse had received an induction there was no evidence of this. The provider told us they had interviewed the nurse pre appointment, but we did not see this information. Recruitment procedures are important to protect people from unsafe care and treatment, abuse and harm.

Systems and processes to safeguard people from the risk of abuse
● We were aware external health care professionals had made safeguarding referrals during 2020 about nursing staff's lack of action in seeking medical attention in a timely manner and meeting clinical care needs. We were aware one investigation about poor clinical care had been substantiated and another investigation, was ongoing at the time of our inspection.

Poor risk assessment of people's care and treatment needs, and a lack of mitigating actions following incidents, placed people at risk of harm. Concerns were identified with nursing staff's clinical skills. This was a Breach of Regulation 12 (Safe Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider had policies and procedures in place in respect of mitigating the risk of Covid-19, although individual Covid-19 risk assessments had not been completed, to guide staff of the care and treatment required should a person become infected. This was a concern as people were vulnerable to infection due to their age, and health conditions. However, staff were knowledgeable about Covid-19 and the action required to reduce the risks of infection. Staff were seen to wear personal protective equipment. The home had only had one case of Covid-19.
● Staff had received safeguarding training and had a safeguarding policy and procedure to support them. Staff were aware of their responsibility to report safeguarding incidents and concerns.

Using medicines safely
● Information to support staff responsible for the safe administration of medicines lacked detail. For

example, one person who had lived at the service for eight months did not have a photograph on their medicine administration record used to correctly identify them. This was a concern because agency staff were used and therefore may not be familiar with people.

● People's allergies were not recorded on the front sheet of their medicine administration record. This is important information that alerts staff to any known risks.

● Medicines prescribed to be administered 'as required' such as pain relief, did not record the maximum dosage that could be administered within 24 hours. This is important information to ensure people are not receiving an excessive dose that could harm them.

● The ordering and storage of medicines followed best practice guidance.

Preventing and controlling infection

● Some furnishings were stained and worn, impacting on them being sufficiently cleaned to reduce cross contamination. The provider identified this issue within their action plan and planned to refurbish the home within the next six-twelve months.

● Some relatives told us they felt the environment could be cleaner, whilst others told us they had no concerns about hygiene and cleanliness.

● Infection and prevention information, including information about Covid-19 was available to staff. We noted this information was not available in easy read to support people's understanding.

● We saw a housekeeper and laundry staff member completing domestic tasks. They told us they had the equipment they required to keep the environment clean and hygienic. They were knowledgeable about the risks of cross contamination and the action required to reduce this.

● Staff were knowledgeable about Covid-19 and the action required to reduce the risks of infection. Staff were seen to wear personal protective equipment.

Inadequate

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Covid-19 had a significant impact upon the service. This had impacted not only on people living at the service, but the staff and management team. The sole Director and owner of the home had passed away and his son had therefore recently taken over management of the home in very difficult circumstances. Several staff had also taken extended time off work to protect their health. This had put additional pressure on the service which appeared to be the cause of many of our concerns.
- Before our inspection, including pre Covid-19 and during the pandemic, we had received concerns from external health care professionals relating to the clinical competency of nursing staff.
- We were also aware the local authority safeguarding team, had investigated concerns about clinical care needs that were found to be substantiated.
- The local authority had completed a virtual audit of the service in June 2020. The result of the audit identified concerns in relation to the management and leadership of the service. Continued concerns were identified in how clinical care and treatment needs were being met.
- During this inspection, we found ongoing concerns about how clinical needs were being met. This is documented in the report under the 'Safe' key question.
- The internal systems and processes to assess, monitor and review quality, safety and risks were ineffective. Whilst the provider had developed an action plan, this was not sufficiently robust and did not provide adequate assurances of how improvements would be made to protect people's safety. Neither did it fully reflect the breaches to regulation identified during this inspection. The provider was working closely with the local authority in respect of the home's progress and an updated action plan was provided following the inspection.
- Due to nurse vacancies, the registered manager was providing nursing care in addition to their registered manager responsibilities. This had impacted on their ability to complete audits and checks that monitored the quality and safety of the service. The registered manager acknowledged they were behind with audits.
- Audits on care plans and risk assessments were last completed in 2018. These audits are important to ensure guidance for staff is detailed and correct, to enable people to receive safe and effective care and treatment.
- From the care records reviewed, these showed care plans and risk assessments had not been evaluated since April 2020. From reviewing incident records, we were aware people had been injured as a result of falls or other accidents. This should have triggered a review of the person's care plans and risk assessment to ensure staff had guidance to reduce further risks. The shows the systems and processes to assess and monitor the service were ineffective.

● We asked to see the last internal medicines audit. The registered manager told us the last audit was completed in 2019. This was a further example of how the system and processes to monitor the service was ineffective.
● Personal emergency evacuation plans had not been reviewed since November 2019. This was despite the registered manager advising us people's support needs had changed.
● Not all staff had received training in areas such as dementia care, catheter care, sepsis and diabetes and they told us this would be beneficial.
● Registered persons are required to submit notifications to CQC, this information enables CQC to monitor services. This includes notifying of serious injury a person has experienced and other incidents such as deaths. From reviewing records, we identified two deaths and a serious injury had not been notified.

Continuous learning and improving care
● Incidents and accidents that had occurred at the service, had not been assessed or analysed for any themes and patterns. This meant there was no opportunity for learning to reduce further reoccurrence.
● The quality of information recorded in incident records was of poor quality. This too had not been identified as an area that required improvement.
● The communication system in place to share information between staff going off duty and coming on duty was ineffective and unsafe. The registered manager advised the exchange of information between staff was verbal only. This lack of recorded information may have impacted on people's safety.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we shared our concerns with the provider. They acknowledged the issues and explained that many of the concerns found were the direct result of the Covid-19 pandemic and the impact this had on the staff and management team. The provider sent us information about actions taken or planned to address the shortfalls found. We will assess the impact of this at our next inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff demonstrated a positive attitude and approach towards the people in their care. Staff told us how Covid-19 had impacted upon them and the service, and in particular the passing of the sole Director and owner of the home. A staff member said, "It has been a rocky road. Especially when [name] passed away. A lot of us have been unwell, including myself."
● Staff told us they believed they were a good team that worked well together. Staff were positive about their role but acknowledged care records needed to be improved upon.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager told us they had not received any complaints since we last inspected the service.
● Relatives told us in the main they were satisfied with the communication they had. Examples were given of how they were informed if their family member had experienced a fall.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Some relatives could not recall being asked to complete a feedback questionnaire, whilst others said they had. One relative said, "Occasionally" and another said, "I think I had a questionnaire a couple of years ago."

Relatives also said they had attended resident and relative meetings, but this had stopped due to Covid-19.
● The registered manager told us they were in the process of sending a questionnaire out.
● Relatives told us they had been made aware of recent changes at the service following the passing of the sole Director and owner of the home.
● Relatives told us how they had been supported to maintain contact with their family member during the restrictions on visitors at the service due to Covid-19.
● Staff meetings and supervision meetings for staff to discuss their training and development needs had been impacted on by Covid-19. The registered manager told us they had started to address this and had provided some meetings. This was confirmed by staff.
● Staff spoke positively about the support from the registered manager and how the provider was asking for suggestions and how they wanted to make improvements at the service.

Working in partnership with others
● The service was being supported by the local authority and local clinical commissioning group.
● The registered manager told us they felt well supported by the local GP practice.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. Regulation 17 Good Governance (1)

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 12 HSCA RA Regulations 2014 Safe care and treatment Poor risk assessment of people's care and treatment needs, and a lack of mitigating actions following incidents, placed people at risk of harm. Concerns were identified with nursing staff's clinical skills. Regulation 12 Safe care and treatment (1)

The enforcement action we took:

NOD served