

Park Homes (UK) Limited

# Winsford Grange Care Home

## Inspection report

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13 January 2022  
20 January 2022  
21 January 2022

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## Ratings

Overall rating for this service

Inspected but not rated

Is the service safe?

**Requires Improvement**



Is the service well-led?

**Requires Improvement**



# Summary of findings

## Overall summary

Winsford Grange is a purpose-built care home for up to 60 people across four separate units. The service provides nursing care for frail older people and people with dementia. At the time of our inspection there were 31 people being supported across three units as one unit had been temporarily closed.

People's experience of using this service and what we found

Risks presented to people and staff by the COVID-19 pandemic were not assessed or recorded and staff were not always being tested for COVID-19 in accordance with government guidelines.

Staffing levels were insufficient to ensure that staff could be deployed in three separate teams during a recent COVID-19 outbreak. This increased the risk of spreading COVID-19. In addition, there were times when people, assessed as at risk of falls, were unsupervised which meant they were at increased risk of harm.

There was a lack of managerial oversight. There was no effective rostering of staff and staffing needs had not been determined by any formal assessment. Staff morale was low. Staff reported a lack of engagement with senior managers. There had been no staff meetings since the new owners acquired the home in October 2021.

The provider was unable to demonstrate that nursing staff and support workers had been recruited safely. Several vitally important checks had not been completed and important documents such as references had either been misplaced or never received.

The provider's quality systems were not sufficiently robust to identify the concerns we identified on this inspection.

The provider was very responsive in taking actions to address the issues we found on inspection however we could not fully assess the impact of these actions until they were fully embedded.

Medicines were stored and administered safely so people received their medicine as their doctor had prescribed it. Some records to support the administration of 'as and when required' medicines was missing.

We have recommended that the provider reviews management and audit of medicines in accordance with best practice guidance.

People were safe and protected from abuse. All people spoken with told us they were safe and well cared for and visiting relatives praised the staff for the standard of care they provided.

The management team were open and transparent throughout the inspection and responded to any requests positively.

### Rating at last inspection

This service was registered with us on 10 October 2021 and this is the first inspection.

The last rating for the service under the previous provider was requires improvement, published on 31 January 2020.

### Why we inspected

The manager notified us of concerns relating to staffing. 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 found no evidence during this inspection that people were at risk of harm from this concern. Please see the safe and well led sections of this full report. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

### Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We have identified four breaches of regulations in relation to safe care and treatment, fit and proper persons employed, staffing and Governance and records at this inspection. Please see the action we have told the provider to take at the end of this report.

Prompt action was taken by the registered provider during the inspection to mitigate risk and improve the quality of care in response to the concerns we found during our inspection.

### Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection program. 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](http://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?

The service was not always safe.  
Details are in our Safe findings below.

**Requires Improvement** ●

### Is the service well-led?

The service was not always well-led.  
Details are in our well-led findings below.

**Requires Improvement** ●

# Winsford Grange Care 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.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

#### Inspection team

This inspection was carried out by two inspectors.

#### Service and service type

Winsford Grange 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.

The service is required to have 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.

The person who was appointed as manager by the provider had not made application to the Care Quality Commission for registration. This person resigned shortly after the inspection and another manager was appointed.

### Notice of inspection

We announced the inspection visit 24 hours before it took place. This was because we needed to give the manager time to prepare in advance of our visit due to the COVID-19 pandemic.

Inspection activity started on 13 January and ended on 27 January 2022. We visited the service on 13, 20 and 21 January 2022.

### What we did before the inspection

We reviewed information we had received about the service since it was registered. We sought feedback from the local authority, and professionals who work with the service. We used all this information to plan our 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.

### During the inspection

During the inspection we spoke with six people who lived at the home and two visiting relatives to gain their views about the care and support provided. We also spoke with 18 staff members including the manager, the acting manager, the regional manager, the business manager, four nurses, an advanced care worker, three support workers, two agency support workers, two housekeepers and an activities coordinator. We looked at the care records for 11 people who lived at the home including the medicine records for five. We looked at the recruitment files for four permanent staff and seven agency staff deployed in the home since registration. A variety of records, relating to the management of the service were also reviewed.

Due to the impact of the COVID-19 pandemic we limited the time we spent on site. Therefore, we requested that some records and documentation be sent to us and reviewed these off site and continued dialogue with the manager by telephone.

### After the inspection

We spoke with a Technical Fire Safety Officer from Cheshire Fire and Rescue Service and with the continued to seek clarification from the manager, regional manager and nominated individual to confirm evidence found. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

# 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 requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

### Staffing and recruitment

- Staffing levels were insufficient to ensure that staff could be deployed in three separate teams during a recent COVID-19 outbreak. This increased the risk of spreading COVID-19.
- There was reliance on agency staff to cover shortages in regular staff numbers. Staff told us they felt this impacted on their abilities to deliver the care people needed as many of the agency staff were not familiar with people's needs.
- There was no effective rostering of staff and staffing needs had not been determined by any formal assessment. Staff told us they were not always supported and were often uncertain as to whether they had been rostered on duty or not.
- There was a lack of managerial oversight. We observed on two occasions people who were at risk of falls, were left unsupervised because staff were busy supporting other people.

We found no evidence that people had been harmed however, there were insufficient suitably experienced and competent staff deployed to ensure the safety and wellbeing of the people who lived at the home. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was very responsive in taking actions to address the issues we found on inspection however we could not assess the impact of these actions until they were fully embedded.

- Safe recruitment processes were not always followed. We found that essential recruitment checks had not been carried out or were inadequately recorded.

We found no evidence that people had been harmed however, the registered provider was unable to demonstrate that safe recruitment procedures had been followed. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was very responsive in taking actions to address the issues we found on inspection however we could not fully assess the impact of these actions until they were fully embedded.

### Assessing risk, safety monitoring and management; Preventing and controlling infection

- When we started this inspection, the registered provider was not taking all reasonable steps to protect the people who lived at the home and staff from risks of the COVID-19 pandemic.

- There were no individual risk assessments for the people who lived at the home or staff that addressed the hazards presented by the COVID-19 pandemic.
- Nursing staff were monitoring for signs of respiratory illness but were not undertaking daily temperature checks.
- Due to a lack of managerial oversight staff were not always being tested for COVID-19 in accordance with government guidelines.
- Infection control training had been provided to staff, but staff had not received updates on changes to Government Guidance or any further training on COVID-19 since October 2021.
- On 20 January 2022 the "nominal role" which is a list of people in the home to be used in the event of a fire and handed to the fire service was not up to date
- On 25 January 2022 the fire officer visited and identified concerns regarding general fire precautions, fire risk assessment and fire training.

We found no evidence that people had been harmed however, systems were not always robust enough to demonstrate risks to people's health presented by COVID-19 were effectively identified and mitigated. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider has acknowledged concerns identified by the fire officer and indicated commitment to address them in liaison with the Cheshire Fire and Rescue Service.
- The provider was very responsive in taking action to address the issues we found on inspection however we could not fully assess the impact of these actions until they were fully embedded.
- The home was open to visitors at the time of our inspection. Arrangements were in place to ensure safe visiting which included a visiting pod. People told us that they were happy with visiting arrangements and we could see that visiting care plans were being drawn up at the time of our inspection.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was admitting people safely to the service.

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

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

#### Using medicines safely

- Medicines were administered in a safe and caring way and at the right times.
- Medicines (including medicines that are controlled drugs) were stored safely and kept at the right temperatures.
- Records ensured that all medicines could be accounted for.
- We found that written information to support the administration of 'when required medicines' was not in place for four medicines.
- Medicine audits included general medicines management and stock counts of people's medicines. However, shortfalls in protocols for the administration of medicines only to be taken when required had not been noted.

We recommend that the provider reviews management and audit of medicines in accordance with best



practice guidance.

Systems and processes to safeguard people from the risk of abuse

- People were safe and protected from abuse. All people spoken with told us they were safe and well cared for. One person said, "Oh yes I feel safe, I am safe and very well looked after."
- Visiting relatives told us their relatives were safe. One relative said: "Yes the staff are lovely, not met one of them who is not committed, they know (relative) very well".
- Staff had received training, understood their responsibilities, and felt able to report abuse should the need arise.

Learning lessons when things go wrong

- Records of accidents and incidents were maintained and analysed to help identify any patterns or trends. Nursing staff confirmed that learning from incidents was shared with them and the wider team at shift handover.

# 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 requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks, and regulatory requirements

- The service was registered under a new provider in October 2021. The transfer had not been well planned and new systems policies and procedures had not always been effectively integrated.
- The manager was new to the role and had not yet applied for registration with the Care Quality Commission. They reported a lack of support and engagement from senior managers.
- Governance and monitoring systems had not effectively identified the issues we found during the inspection. Some audits had been carried out but had not been effective.
- Failure to identify, assess and mitigate shortfalls in infection prevention and control, staffing and staff recruitment meant people were at increased risk of harm.
- The provider had a range of policies and procedures but these had not been shared with all staff and were not available for staff to read on each unit.

Systems and records were not always robust enough to demonstrate risks to people's health were effectively monitored. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was very responsive in taking actions to address the issues we found on inspection however we could not fully assess the impact of these actions until they were fully embedded.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Nursing staff, support workers and others staff spoken with reported low morale. They told us that colleagues had left, and others were contemplating leaving because of a lack of managerial direction and support.
- There had been no staff meetings other than shift handovers since the new provider acquired the home.
- The manager was seemingly unaware of important issues and incidents that had occurred in the home and there was an apparent disconnect with some nursing staff and care workers.
- Despite the low morale and lack of managerial oversight, staff understood the provider's values and beliefs in caring for people and providing person centred care. This was reflected in the way staff responded to and involved people in all aspects of their care.

- All people spoken with spoke highly of the staff and the standard of care provided. We could see that staff and the people who lived at the home enjoyed good relationships with evidence of warm caring and positive interactions.
- Nurses and care workers had received training in equality and diversity and had a good understanding of protected characteristics.
- The provider was very responsive in taking actions to address the issues we found on inspection. A new suitably qualified and experienced manager was appointed during our inspection.

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; Working in partnership with others

- The provider understood their responsibility to comply with the duty of candour and met the regulatory requirements to be open and transparent with people using the service when things went wrong.
- The Commission had been notified of all notifiable incidents that had occurred in the home.
- Managers, the nominated individual and staff worked cooperatively with us and in the best interests of the people who lived at the home.
- An associated social care professional told us that the new manager had been responsive to any request for information and was assisting them with their enquiries.

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 12 HSCA RA Regulations 2014 Safe care and treatment  Systems were not always robust enough to demonstrate risks to people's health presented by COVID-19 were effectively identified and mitigated.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  Systems and records were not always robust enough to demonstrate risks to people's health were effectively monitored.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed  The registered provider was unable to demonstrate that safe recruitment procedures had been followed
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  There was an insufficient number of suitably experienced and competent staff deployed to ensure the wellbeing of the people who lived at the home.

