Barchester Healthcare Homes Limited

The Wingfield

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Wingfield is a care home providing personal and nursing care to 57 people. The home is made up of two buildings, The Lodge and Memory Lane. The service can support up to 89 people.

People's experience of using this service and what we found
The provider had not notified CQC of significant events in the home when they were legally required to. These were incidents in which people had sustained injuries or where there had been physical altercations between people living in the home. The provider had taken appropriate action after these incidents to keep people safe.

We have made a recommendation about statutory notifications required by the service.

The provider had infection prevention and control procedures in place. However, some staff were observed not wearing PPE correctly which the provider addressed with additional training. Cleaning was observed throughout the service however wasn't recorded clearly.

Recent changes in management of the service hadn't been communicated to the majority of relatives. Relatives felt people didn't receive enough activity throughout the day to keep them engaged. Individual interactions between people and staff were caring and people appeared comfortable with staff.

Relatives told us they felt their loved ones were safe and happy at the home. The pandemic had impacted relative's involvement with reviewing people's care plan. However, relatives were kept updated with any changes in people's health. Provision had been made to ensure people were able to maintain contact with those important to them throughout the COVID-19 pandemic.

There were safe recruitment practices that followed legal requirements. People received their medicines as prescribed. Staff understood how to protect people from the risk of abuse and knew what to do if they suspected something was wrong. Risks to people had been assessed and staff knew how to manage these risks safely. There was a process to identify learning from accidents, incidents and safeguarding concerns.

People's communication needs were met. Staff understood how to provide a person-centred service. The service had a policy in place to provide people with end of life care if required.

Staff received appropriate training and supervision and had the knowledge and skills to provide the care people needed. Staff knew people well and supported them to stay healthy.

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 24 May 2019).

Why we inspected
We received concerns in relation to people's nursing and personal care needs, staffing levels and the management of the home. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only.

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.

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. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Wingfield on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our reinspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

The Wingfield

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
The inspection was carried out by three inspectors. The inspection was also supported by two 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.

Service and service type
The Wingfield 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 did not 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 used all of this information to plan our inspection.

During the inspection-
We spoke with 16 relatives about their experience of the care provided. We spoke with 25 members of staff including the manager, regional director, nurses, senior care workers, housekeeping staff and activities co-ordinator. We 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 reviewed a range of records. This included 11 people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

Requires Improvement

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 requires improvement.

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

- There were enough staff on duty to ensure people's care needs were met.
- The manager used a dependency tool which assessed the number of people and their care needs to deploy staff with the right skill mix. Staff rota's showed staffing levels in line with their dependency tool. However, staff felt they were rushed and not able to spend quality time with people to provide person centred care. Staff told us, "We are quite stretched, it's not fair on the residents" and "it's not about numbers but about the quality as well." Another said, "I do feel we do not have enough time to mentally stimulate residents."
- Staff told us no one had been harmed and people's needs were being met. One staff member said, "It's okay, they're [staff] managing to get things done." The manager and regional director were aware of the concerns and were speaking to staff about staffing levels.
- Relatives told us people often walk into each other's rooms and felt this was due to the amount of staff. "We were there this week and 10 residents came into her room while we were there." Another said, "[Person] is not overly fond of other residents coming into her room."
- One relative said, "There have been lots of changes of staff which makes it more difficult for them to get to know [person]." Another told us; "The staff don't change, [person] has her favourites."
- The service checked the registration and professional qualifications of staff regularly, and supported staff with their ongoing professional development. This meant that people were cared for by staff who were qualified and knowledgeable in their field.
- People were protected by safe recruitment processes. Staff had pre employment checks, these included checks with the Disclosure and Baring Service (DBS) and obtaining suitable references.

Preventing and controlling infection

- We observed a number of staff not using their facemasks in line with current PPE guidance for care homes. This included wearing facemasks around their chin or below their nose. When we discussed this with the management team, they told us these members of staff had reasonable adjustments to take regular breaks however they were unable to provide a risk assessment to support this on the day. The management team said refresher training would be put in place.
- During the second day of the inspection the operations trainer was delivering refresher training with staff and checking correct PPE practices were being followed.
- The home appeared clean, tidy and smelt fresh. We observed cleaning in people's rooms and communal

areas. However, cleaning records were incomplete for communal high risk areas in the home. Also four days didn't have any record that cleaning had taken place in people's rooms or communal areas on the first floor.

● We were assured that the provider was preventing visitors from catching and spreading infections. One relative told us, "I wear all the items and have a test before I go in."
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Using medicines safely
● Medicines were managed safely. Prompt and appropriate action was taken to address any shortfalls.
● Medicines were stored securely, and only administered by staff who were suitably trained.

Assessing risk, safety monitoring and management
● Risks were assessed to ensure people were safe and staff took action to mitigate the risk of avoidable harm. Risk assessments were regularly reviewed to reflect people's changing needs.
● Staff followed people's care plan regarding skin care. One person had suffered from a pressure wound. They were receiving care from community nurses. Their care plan contained positioning guidance; there were repositioning charts in place which were up to date and relevant. Another person was assessed as being at high risk of pressure damage and had appropriate pressure relieving equipment in place.
● The home carried out safety checks on the environment. These included checks on electric, gas, water and fire safety and equipment within the home. People had individual evacuation plans in place highlighting the level of support needed for each person in the event of an emergency.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse, as the provider had systems in place in identifying and responding to any concerns identified.
● Staff were aware of the provider's whistleblowing procedures and told us they felt confident to raise concerns. One staff member told us, "I would report it to the nurse, take it to the manager." Another staff member said, "If I had any suspicions of any resident being harmed or abused, I would report it to the management team."
● A relative said, "I'm very pleased with the quality of care [person] gets, [person] is well looked after." Another relative told us, "100% safe there, I'm so happy."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● The provider had engaged activity coordinators to support people with activities on a daily basis. However, feedback was mixed about the variety and access to take part in activities. Relatives told us, "There's a sheet on the door about activities but [person] couldn't participate. I'm not aware of any activity in her room." "They do quite a few activities, [person] enjoys the sing alongs." Another said, "It would be nice to be told what is going on so I can encourage [person] to go to activities."
● One health professional told us they've spoken with the management team about activities in the service, "I have ongoing concerns about the apparent lack of structured activity and opportunities for occupational activity."
● The provider continued to allow people to have visits during the COVID-19 pandemic. They provided people's relatives with a visiting area, PPE and lateral flow tests.
● Families also stayed in touch with people via video and telephone calls. The provider made a tablet available to people for video calls. However, care coordinators facilitated these calls which reduced their time to engage with people in the service. One relative said, "I'm absolutely happy with the contact during this period. There was an [device] in the home and we could Skype for half an hour."

Improving care quality in response to complaints or concerns
● The provider looked at complaints to see if anything could be done differently. However, a recent complaint from relatives that raised concerns and prompted the inspection at The Wingfield hadn't been addressed fully in their response. The manager told us a more detailed explanation will be sent to the relatives covering all their concerns.
● Relatives said they're confident to speak with the manager and raise any concerns. The majority of relatives we spoke with didn't know the manager had left and who to contact. Relatives said, "I raised a concern with [previous manager] and she addressed it." Another said, "I am unsure about raising something with the interim manager or wait until they get a permanent manager."
● A complaints, concerns and compliments policy and procedure was in place. This detailed how complaints could be raised, timescales for a response and how actions would be communicated.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● People's care plans included life histories. This meant staff were aware of people's life stories and were able to better understand what may be important to each individual. One relative told us, "They've [provider] been good asking me about stuff and I have been sent a booklet about [person]."

● We observed that staff knew people well and understood people's different communication styles. This meant staff were able to understand people's preferences, support individual choice and support people where necessary.
● People's care and support plans were reviewed to account for any personal or health changes. However, feedback was mixed from relatives and their involvement in the review. One relative said, 'I think there is a care plan I haven't been involved." Another told us, "We did a plan originally. Since the pandemic I did one over the phone."
● Care plans reflected advice and guidance from visiting healthcare professionals.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carer's.
● People's communication needs were described in their care plans. Staff told us they were able to communicate with people by using calm and reassuring language.
● Staff were observed to take time when communicating with people. They demonstrated understanding of the additional difficulties wearing face masks presented to people. Efforts were made to gain eye contact with people.

End of life care and support
● People had their end of life wishes documented in their care plans, this included where they would like to die, what treatment they would like to receive and wishes regarding funeral arrangements.
● Staff told us they were confident in providing end of life care and were confident and passionate about doing so.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff felt the lack of a stable management team affected the running of the service. Staff said, "There is no support from above; the manager is here two or three times a week." Another said, "At the present time we do not have a permanent manager and I feel this needs to be resolved."
- Some relatives told us that communication needed to be improved. One relative said "I have found communication not to be that good. I have been chasing them." The majority of relatives we spoke with hadn't been informed the manager had left the service. During the inspection the provider sent a letter to relatives updating them of the changes in management and who to contact.
- Although people commented to us about a lack of management presence, they told us that they felt they could put forward ideas and suggestions to staff.
- During the inspection we observed positive interactions between people using the service and staff.

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

- The manager had a good understanding of their responsibilities for sharing information with CQC. However, the service hadn't submitted two statutory notifications as required under the previous management. The service had taken appropriate action after these incidents to keep people safe. This was brought to the managers attention. A notification is the action that a provider is legally bound to take to tell CQC about any changes to their regulated services or incidents that have taken place in them.

We recommend the provider seeks guidance on their quality assurance systems to ensure they are submitting all legal notifications.

- The service did not have a manager registered with CQC. The regional director and an interim manager were overseeing the running of the service during the inspection. A previous manager was in the process of returning and applying to CQC for registration.
- The provider and management team were working towards improvements in the service. The management team were responsive to feedback during the inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider engaged with residents at monthly meetings. The regional director told us a yearly survey is sent to relatives but wasn't completed last year due to the pandemic. A survey was being sent out to relatives in September 2021. Quarterly relative meetings continued during the pandemic and were held online.

● Relatives gave mixed responses about having the opportunity to engage with the service. One relative said, "sometimes I have had an email and I have done written feedback." Another told us, "I've not had a questionnaire. Never been asked to attend meetings."

● There were daily "stand up" meetings to share information with all heads of departments and clinical governance meetings to look at all aspects of a person's care. This involved looking at pressure damage, infections, falls, weight loss, illness and any other areas of concern. This meant that trends could be identified, and health interventions put in place to support the individual.

● Staff received regular surveys which the regional director reviewed to identify areas of improvement and responded to staff using "you said, we did".

Working in partnership with others; Continuous learning and improving care

● Accidents and incidents were monitored and analysed to look for patterns and trends, to learn from them.

● Quality assurance systems were in place which monitored the risks to people's health and identified actions to improve the quality of care. The regional director completed regularly reviews which provided further oversight to drive improvements in the service.

● We saw evidence of partnership working with other agencies to meet people's needs. Such as, dementia specialists, speech and language therapists and the falls team. One health professional said, "I always get prompt referrals" and the service had been quick to respond during the pandemic.

● The service maintained links with community contacts during the pandemic and planned to invite people back to the home with the easing of COVID-19 restrictions.