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Winterbrook Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on the 25 and 26 August 2016.

Winterbrook Nursing Home provides accommodation for up to 41 people requiring nursing or personal care. At the time of our inspection there were 29 people using the service.

There was a registered manager in post. 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 promoted a person-centred culture and ensured people were at the centre of all the service did. There was a cheerful, relaxed atmosphere throughout our inspection. People were spoken to with kindness and compassion and were able to spend their day as they chose. Staff were caring and respected people's choice. People were encouraged to maintain and improve their independence.

People felt safe in the service and were supported by staff who understood their responsibilities to report any concerns relating to abuse. There were sufficient staff to meet people's needs and people benefitted from a consistent staff group. There were recruitment processes in place, however the provider had not always obtained two references before staff started work in the service.

Medicines were managed safely. People received their medicines as prescribed by staff who had the skills to do so.

People had personalised care plans that detailed the support they needed. Staff were knowledgeable about people's needs. Where risks were identified there were plans in place to manage the risks.

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA). However there was not always evidence to show people's capacity had been assessed and a best interest process followed.

Food provided was appetising and people were complimentary about the quality of the food. Individual dietary needs were met. People had access to health professionals when needed and any guidance given was followed.

Staff felt supported and listened to. Staff had training to ensure they had the skills and knowledge to meet people's needs. Staff were supported to improve their skills and were offered development opportunities.

The provider sought feedback from people and their relatives about the quality of the service and feedback was used to improve the service. There were effective systems in place to monitor and improve the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was not always safe.

Records relating to the administration of medicines were not always completed.

Staff understood their responsibilities to identify and report concerns relating to abuse of vulnerable people.

There were sufficient staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager and staff were not always clear about their responsibilities in relation to the MCA and DoLS.

People were complimentary about the food and drink provided. People's specific dietary needs were met.

People had access to health professionals when needed. Advice and guidance provided was followed.

Is the service caring?

Good

The service was caring.

Staff were kind and treated people with respect.

People were encouraged to be as independent as possible.

People were involved in decisions about their care.

Is the service responsive?

Good

The service was responsive

People's needs were assessed prior to using the service. Assessments were used to develop personalised care plans.

People had access to activities that interested them.

There was a complaints process in place and people knew how to complain.

Is the service well-led?

Good

The service was well led.

The registered manager was approachable and spent time talking with people.

There were effective quality assurance systems in place to monitor and improve the quality of the service.

Accidents and incidents were recorded and monitored to identify trends and patterns.

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 25 and 26 August 2016 and was unannounced.

The inspection was carried out by two inspectors and an expert by experience (ExE). An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law. This ensured we were addressing any areas of concern.

During the inspection we observed practice throughout the home. We carried out a 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 also observed care practices throughout the day.

We spoke with nine people who used the service and seven relatives. We also spoke to the operations director, the provider, the registered manager, the clinical lead, two nurses, three care workers, an activity coordinator, the maintenance person and the chef.

We looked at eight people's care records, including medicines, seven staff files and records relating to the management of the home.

We received feedback from two healthcare professionals and the commissioners of the service.

Good

Is the service safe?

Our findings

People told us they felt safe. Comments included: "I am safe because I am well looked after"; "Very safe, treated very well. Any problems; tell somebody and they deal with things" and "Carers check us at night. It is very reassuring". Relatives were confident people were safe. One relative told us, "[Person] is very safe here. I am delighted [with care]".

Staff had a clear understanding about their responsibilities to identify and report any concerns relating to the abuse of vulnerable people. Staff knew the outside agencies they could report concerns to if they felt action had not been taken by the provider. One member of staff said, "I can alert CQC or go to the Police if needed". Staff had completed safeguarding training and were provided with a pocket sized 'prompt card' to ensure they had the appropriate contact details to report a concern.

There was safeguarding information displayed in the home for people, relatives and staff which gave details of how and where to report any concerns. The provider had a safeguarding policy and procedure in place and records showed all safeguarding concerns had been fully investigated and appropriate agencies notified.

Medicines were managed safely. Staff responsible for the administration of medicines had been trained and assessed as competent before administering medicines. Qualified nurses completed the medicine administration and were responsible for the management of medicines. We observed people being supported to take their medicines. The nurse took time to explain to people what medicines were for and made sure they were happy to take them. The nurse returned to people who were eating or being supported with personal care to ensure they were able to concentrate on taking their medicines. Where people were prescribed 'as required' (PRN) medicines the nurse asked the person if they required the medicine and gave the person time to consider their response.

People's medicine administration records (MAR) included details of allergies, medical conditions and a photograph of the person. MAR were completed accurately and confirmed people were receiving their medicines as prescribed. Where people were prescribed PRN medicines, there were protocols in place to ensure people were provided with medicine when needed.

Room and fridge temperatures were checked daily to ensure medicines were stored at the correct temperature. The clinical lead completed regular medicine audits to ensure medicines were managed safely. These audits had identified that MAR had not been completed consistently and in line with the provider's policy when people were offered PRN medicines and declined. The clinical lead advised us this was being addressed with staff responsible for administering medicines. We saw notes from a nurses meeting that showed the issue had been discussed.

Where people were prescribed topical medicines, records were kept in people's rooms and completed by care staff who applied the topical medicine. Topical medicines are medicines that are applied to a certain part of the body, for example creams and ointments. We saw that topical medicines had been marked with

the date they were opened. Records relating to the administration of topical creams included body maps to identify where the medicine should be applied and details of the time and frequency of application.

People's care plans contained risk assessments and where risks were identified there were plans in place to determine how risks would be managed. For example, one person was at risk in relation to their mobility. The person's care record contained a detailed moving and handling care plan which gave clear instructions to staff in how they should support the person. We saw staff following the care plan. However, risks relating to pressure care were not always identified and care plans did not always contain up to date information relating to pressure relieving equipment in place and its use. We spoke to the registered manager and clinical lead who took immediate action to ensure information was updated. No one in the home had a pressure sore at the time of our inspection.

We looked at the recruitment files for eight staff. We saw that most files contained evidence of robust recruitment processes which included: proof of identity; employment histories, with any gaps in employment explored; DBS checks and references from previous employers. However, two recruitment files for staff who had recently started working at the service contained only one reference. We spoke to the registered manager and the operations director who advised us that the human resources department were still trying to obtain the second references for these employees. They told us all new staff were monitored closely to ensure they were competent before working alone.

There were sufficient staff to meet people's needs. One person told us, "Always staff about, makes it feel safe". Another person said, "Seem to have plenty of staff". Throughout the inspection we saw that people's requests for support were responded to promptly. Call bells were answered in a timely manner. Staff did not appear rushed and had time to spend sitting and speaking with people.

The registered manager used a dependency assessment tool to provide a guide to the staffing levels required to meet people's needs. We looked at the staffing rotas for June and July and saw the required numbers of staff had been available at all times.

People's care records contained personal evacuation plans and there were clear fire evacuation signs throughout the service. There was a maintenance person in post who ensured that the premises and equipment were safely maintained. We saw that equipment was serviced by external contractors where specialist knowledge was needed. For example, hoists, assisted baths, fire equipment and lifts.

Requires Improvement

Is the service effective?

Our findings

The registered manager had understood their responsibilities in relation to the Mental Capacity Act 2005 (MCA). 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.

The registered manager had made an application to the supervisory body for a Deprivation of Liberty Safeguard (DoLS) for one person. People can only be deprived of their liberty so that they can receive care and treatment where they are assessed as lacking capacity and it is in their best interests. The deprivation must be legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). However, there was no system in place to ensure assessments and decisions had been properly taken for other people who may have been deprived of their liberty.

Where people were not able to consent to their care and treatment there was not always a capacity assessment to support the decision being made on the person's behalf. For example, where people were being supported by the use of bedrails there was no record of a mental capacity assessment to determine if the person could consent to the use of bed rails. There was no evidence of a best interest process being followed to ensure the bed rails were in the person's best interest and the least restrictive option. We spoke to the registered manager and operations director about these issues and they told us they would take immediate steps to address them.

Most staff were knowledgeable about the Mental Capacity Act 2005 (MCA) and understood how to apply the principles of the act when supporting people. One member of staff told us, "I'm aware that someone with dementia could mean their capacity could fluctuate. For example, if bed rails were needed it would be the choice of the person where possible, or we could consider other measures, such as lowering the bed. If we had any doubt we would make a best interest decision". However, newer members of staff were not always clear about their responsibilities in relation to MCA. We spoke to the registered manager, who had identified the e-learning training in relation to MCA had not been effective for all staff and had arranged for some face to face training to support staff's understanding.

Throughout the inspection we saw people being supported in line with the principles of MCA. People were consulted before being supported by staff. People were given time to understand and respond to questions and their decisions were respected. Where people were unable to respond staff ensured people were comfortable with the support being offered by looking for visual prompts and responding to people's body language.

Staff had the skills and knowledge to meet people's needs. One relative told us, "They do many days of training for this job. Well trained here". Staff felt well supported in their roles. One member of staff told us, "I can approach my line manager for support and advice at any time, yes I do feel supported". Staff had regular supervisions and appraisals which staff found useful in enabling them to discuss any issues and concerns

relating to the service.

Staff completed training which included: safeguarding, Mental Capacity Act, moving and handling, dementia care and specific training such as enteral feeding pump (this is a means of delivering nutrition to people whose nutritional needs cannot be met orally). Two care workers told us they had completed an induction which included the provider's mandatory training. New staff were allocated a mentor to support them when they first started. Regular meetings were held between the new staff and their mentors to ensure new staff felt well supported in their role. Where staff identified specific training to help them develop in their role they were supported to identify and access training. For example, the clinical lead told us they were responsible for mentoring staff and had just completed a mentoring programme at a local university.

Staff had access to development opportunities and to obtain qualifications. Staff had completed level two and three diplomas in social and healthcare. One care worker was being supported to complete an access course to enable them to study for a nursing degree.

People were complimentary about the food and drink they received. Comments included: "Food is very good"; "Lovely dinners. Hot, tasty and just the sort of food I eat"; "Very good food and I am enjoying it" and "Food is tasty. If you want anything special you can have it". Relatives were equally positive about the food on offer. One relative told us, "I have had dinner with [person] a few times and food is very good".

Where people had specific dietary requirements this was detailed in their care plans and we saw people received food and drink to meet their needs. For example, one person required pureed food and for their drinks to be served in a beaker without a lid due to swallowing difficulties. Staff were knowledgeable about the person's needs and ensured the person was supported in line with their care plans. Where people were at risk of weight loss food was fortified and their weight regularly monitored. The chef was notified of people's dietary requirements and any likes and dislikes when people moved into the home. The chef was knowledgeable about individual needs. Throughout the inspection people were supported with regular drinks. Snacks were available throughout the day, which included fruit and homemade cakes.

People were supported to access health professionals when required. One health professional who provided feedback prior to the inspection told us referrals were made appropriately. People's record showed they had access to the care home support service (CHSS), G.P, podiatrist, dentist, speech and language therapist (SALT) and community mental health teams. Where professional advice was given, this was detailed in people's care plans and guidance followed.

Good

Is the service caring?

Our findings

People benefited from staff who were kind. People and staff had developed caring relationships with each other. People told us: "People (staff) who look after me are very good"; "People (staff) know how to care for you"; "People (staff) are kind and friendly" and "They are all very caring. They know what you need and do it".

Relatives told us staff were caring. One relative said, "Really very caring, very friendly. They know all the residents by name".

When we spoke with staff, they spoke about people in a caring, respectful manner. One member of staff said, "Building up trust is essential to developing a good relationship with people". Other staff comments included: "I treat people as I would my own relative"; "Seeing people smile is what makes me enjoy my job" and "Helping people is the best thing about my job".

We saw and heard many kind and caring interactions throughout the inspection. Staff addressed people by their chosen names and took time to ensure people were comfortable and had everything they needed. When a person requested help a member of the care staff responded in a cheerful manner saying, "Of course I can". Care workers used a gentle approach with people and language that was respectful. For example, a person appeared to be struggling to eat; a care worker approached and offered to help the person move nearer to the table. Once the person had been supported the care worker checked they were more comfortable.

People told us they were treated with dignity and respect. One person said, "People are treated with respect. Staff are extremely well informed and know individual needs". We saw that staff knocked on people's doors before entering and ensured doors were closed before providing personal care. Staff were respectful and discreet when people's dignity was compromised. For example, one person was being supported to walk to the dining table. The person's trousers started to slip down. The care worker immediately put their hand on the person's arm and indicated for them to stop walking. They spoke quietly into the person's ear and rearranged their clothing. On another occasion a person was being supported to transfer from their wheelchair into an armchair using a hoist. Staff explained what was happening at every stage and covered the person's lower body to ensure their dignity was protected.

People were encouraged to be as independent as possible. One person told us, "They have prepared me for outside. When I first came in here staff did everything for me. When I had a shower I expected them to be there. Now I do everything for myself. I have got my independence back and I pick up my keys to my bungalow today". The person was clearly delighted that they were now going to live independently.

People told us they were involved in decisions about their care. Comments included: "Always asking me if I am happy with my care. If I want anything changed"; "Discuss my care every six months or so" and "Will talk through things with me". Relatives were involved in people's care where needed. One relative said, "We talked about care and treatment when [person] first came in. I know that I can come in for a chat whenever I

like". Relatives told us they were contacted if there were any concerns and were always able to speak with a member of staff or one of the management team at any time.

Good

Is the service responsive?

Our findings

People were assessed prior to moving into the home and these assessments were used to develop care plans that identified how people's needs were met. People's care plans were personalised and included details of people's chosen routine. For example, one person's care plan stated "Likes to wander down in their own time for breakfast". Care plans also included information about important relationships and who the person had built relationships within the home. We saw that care staff knew this information and ensured people sat with friends throughout the day.

People's records included life story books to enable staff to know about people's lives. For example, one person's life story book described their childhood and their occupation. It also included details of the person's family and their likes and dislikes. The life story book stated the person liked "roses, lavender and dogs". Care staff showed a good knowledge of people as they chatted with them. For example, one person's care plan stated they liked singing. We saw staff singing with the person. The person joined in the singing, smiling as they did so. It was clear they enjoyed the interaction. Care plans were reviewed monthly and updated to reflect people's changing needs.

People told us there were a range of activities available and they could participate if they wished. Comments included: "I join in with the activities. Exercises are very good and I enjoy trips out"; "Every day we have exercise sessions, very enjoyable"; "Enough to do, lots of fun" and "A lot going on, almost too much sometimes". People told us about a barbeque that had taken place prior to our inspection. People had clearly enjoyed the event and were still talking about it during our visit. The barbeque had included relatives and staff.

The home employed an activities coordinator who organised activities. Activities included: a daily exercise class; arts and crafts and reminiscence sessions. The service encouraged community involvement which included visits from children at a local school, a weekly church service and a volunteer who supported a knitting club. People were invited to and attended performances by a local theatre group and enjoyed trips out which has included a visit to a nearby RAF base, garden centres and local pubs.

On the day of the inspection the RAF base had an open day. People were supported to sit in the garden and watch the air displays. While people were outside it started to rain. People were supported to return inside. However, some people chose to remain outside. Care staff were supportive and made sure people were sat under umbrellas, respecting their choice to remain outside.

People were able to spend their day as they chose. Some people preferred to remain in their rooms and were visited regularly by care staff to reduce the risk of social isolation. Most people spent their day in one of the home's communal areas.

People and relatives told us they knew how to make a complaint but had never needed to. Where there had been minor issues people told us the service responded promptly and resolved issues. One person said, "I'd tell [registered manager], always about the place". A relative told us, "Any worries go to the right person, if

need be then they will pass me on to somebody who can deal with the problem".

The provider had a complaints policy and procedure in place and this was displayed throughout the home. Records of complaints showed complaints had been dealt with in line with the provider's policy and to the satisfaction of the complainant. The registered manager used complaints to improve the service. For example, there were posters displayed throughout the service encouraging people and relatives to raise any concerns they had immediately in order for the problem to be resolved. The registered manager explained these had been put in place following a complaint that had come in via a third party sometime after the issue had occurred. The registered manager wanted to have the opportunity to resolve issues as they occurred.

Good

Is the service well-led?

Our findings

People and their relatives were complimentary about the registered manager and the quality of the service. Comments included: "The manager has created a good atmosphere here"; "The manager doesn't miss much, she is pleasant and easy to talk to"; "It's a nice atmosphere. Lots to do and very friendly" and "I don't think you'll find any problems here, it's very good".

Staff were equally positive about the registered manager and the support they received from the management team. One member of care staff said, "The manager is 100% behind what I do here". Another member of care staff said, "Very good mentor. Good team work with other staff". Staff told us they felt supported and listened to. There were regular staff meetings where staff were kept informed about changes to the service and issues discussed. For example, we saw notes from one staff meeting that showed the implementation of an electronic care plan system had been discussed.

Throughout the inspection we saw the registered manager and operations director sat chatting with people. It was clear people knew who they were and were comfortable talking with them. People and relatives told us the registered manager was approachable. We saw many interactions between the manager and relatives as they visited the home. The registered manager had developed positive relationships with relatives which they valued.

There was a person-centred culture in the service that put people at the centre of all the service did. The manager promoted this culture and ensured staff understood the importance of person-centred care. For example, the registered manager carried out regular observations of care staff throughout a shift. This was then discussed with the member of the care staff and documented in a 'record of experience'. The observation was detailed and highlighted areas of good practice, areas for improvement and was focused on people and their involvement.

People told us they were asked for their views about the service and their opinions were listened to. For example, the lounge area of the home was being refurbished. People had been consulted about the décor. We saw one wall in the lounge had been painted. The registered manager told us people did not like the colour so alternative colours were being considered before the painting continued.

The provider carried out surveys twice a year to seek feedback from people using the service. There were regular meetings with people and relatives to keep them informed about the service and to discuss any issues. Feedback was used to improve the quality of the service. For example, people had commented about the food choice. We saw that action had been taken to change the menus and people were positive about the food now offered.

The registered manager and operations director were constantly looking for ways to improve the service and to address any areas of concern. For example, we saw that the carpets in the home were stained. The operations director told us the carpet cleaning machines they had in the home were not effective and they were currently arranging for an industrial cleaning company to come in and clean the carpets. The provider

and operations director were sourcing an electronic care planning system. The operations director was clear that the implementation would be done in a staged approach to ensure staff confidence in using the system and reduce impact on people using the service.

There were quality assurance systems in place to monitor and improve the quality of the service. Regular audits were completed and actions taken as a result. Audits included; medicines, care plans and infection control. We saw that audits had identified some of the issues we found during our inspection and steps had been taken to address the issues.

Accidents and incidents were recorded and identified actions taken to minimise the risk of further incidents. The registered manager kept an overview of all accidents and incidents to look for trends and patterns. For example, all falls were monitored to identify if there were common themes for either individuals or across the service.