RCH Care Homes Limited

Withens Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Withens Nursing Home is a nursing home providing personal and nursing care in one adapted building for up to 33 people aged 65 and over. At the time of the inspection there were 18 people at the service. They had a communal lounge and conservatory area with a separate dining room. The service is laid out over two floors, upper floors are accessible via a lift.

People's experience of using this service and what we found
People told us they felt safe living at the service. However, risks to people's health and welfare were not always assessed and action had not always been taken to manage risks and keep people safe. Accidents and incidents were recorded, but analysis was not in-depth and lessons had not always been learnt to prevent them happening again.

There were not enough staff to meet people's needs consistently and keep people safe. People received their medicines when prescribed. However, topical medicines such as creams and medicines requiring refrigeration had not always been stored safely.

There was a manager in post who had started in May 2020 and was in the process of registering with the Care Quality Commission (CQC).

There were systems in place to monitor and check the quality of the service. However, these had not been effective in identifying issues we found on our inspection.

The manager had not always referred safeguarding incidents quickly, and they had not always notified CQC of incidents as required.

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 coronavirus and other infection outbreaks effectively.

The service was working within current infection control guidance and staff were wearing personal protective equipment as required. The service was clean and there were cleaning schedules in place to reduce the risk of infection.

People were asked their opinions on the quality of the service during meetings. Staff meetings were held regularly where staff could raise any concerns they had. The manager had focused on team building, staff told us this had improved, and they now felt more supported.

Staff continued to work with other health professionals to meet people's health needs and ensured good communication between staff, local hospitals and GP's .

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 7 December 2017).

Why we inspected
We undertook this focused inspection in response to concerns about safe care and treatment of people using the service. This report covers our findings in relation to key questions 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. 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. You can see what action we have asked the provider to take at the end of this full report.

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

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 will continue to monitor the service. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risk management, staffing and notifications at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Withens 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.
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 two inspectors that attended the service. Assisting the inspection off site was another inspector, who reviewed documents and an assistant inspector who made telephone calls to relatives and staff.

Service and service type
The Withens 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 did not have a manager registered with the Care Quality Commission. A new manager started at the service in May 2020 and had applied but not yet registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We gave a short period notice of the inspection. This was to check if any staff or people at the service had tested positive or had symptoms of Covid-19 and to discuss arrangements for the inspection and PPE required.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with eight members of staff including the quality manager, home manager, nursing staff, care workers, housekeeping and the chef.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including safeguarding records.

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 seven relatives to get their feedback on the care their relative received.

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.

Assessing risk, safety monitoring and management, learning lessons when things go wrong

● Accidents and incidents had been recorded but limited analysis was in place. Accident forms identified multiple unwitnessed falls had happened at night time. The times when unwitnessed falls had occurred were not recorded on the analysis, therefore any patterns linked to staffing levels would not be identified. The manager agreed having a more detailed analysis would help identify any action needed for example reviewing staffing levels and people's needs.

● One person was admitted to the service. A pre- assessment of their needs was carried out but failed to identify they liked to walk around a lot and that they might leave the building alone. Strategies had not been implemented and the person left the service unsupported twice, putting them at risk. Lessons had not been learnt from the first incident and placed this person at continued risk of harm as it happened again.

● Some people with swallowing difficulties required thickening powder in their drinks. If thickening powder is swallowed without fluid, it can form an obstruction and people would be at risk of choking. During our inspection we observed that this powder was not always stored appropriately. For example, in one person's bedroom it was left on their table next to their drink, the person had easy access to the powder. Some people were living with dementia and may be confused placing them at risk of ingesting the powder. This was rectified by the manager when we brought it to their attention.

● Risks to the environment had been assessed, but action had not always been taken to keep people safe. Where people have access to hot water, the temperature should not exceed 43 ° C this is to reduce the risk of scalding. Hot water temperatures in bedrooms and bathrooms had exceeded this level. We found this occurred for two weeks leading up to the inspection and no action had been taken by the provider to reduce the risk of scalding from water that was too hot. On the day of the inspection action was taken to rectify this issue.

● There was a fire risk assessment in place and people had personal emergency evacuation plans in place. However, a recent fire evacuation drill in May 2020 showed staff were unaware of their roles during a fire evacuation. The manager and provider were not aware this had happened and could not demonstrate how this had been addressed. There was a risk that staff would not be able to evacuate people safely in the event of a fire. The manager arranged a practice drill the next day so they could be assured staff were clear on their roles.

● People's individual health risks were managed. Staff had identified people at risk of malnutrition, and made appropriate referrals to health care professionals. Kitchen staff were aware of people who required their meals modified and how to do this.

Using medicines safely

● People's medicines were not always stored safely which placed them at risk of harm. Fridge temperature

checks were being carried out to ensure medicine was stored at a safe temperature of between 2-8c. However, it had been logged that temperatures had reached as high as 18 degrees. The fridge stored medicines such as penicillin which was administered daily to help maintain blood sugar levels. If this medicine is not stored correctly it can affect the way medicine works. The provider had not ensured appropriate action had been taken in a timely way to ensure medicines were kept safe. The provider took action during our inspection to ensure the medicines were stored safely.

● We found that topical medicines such as creams were not always stored safely or in line with best practice guidance. Prescribed creams were kept in people's rooms, staff told us that daily temperature checks of bedrooms were not in place. On days leading up to the inspection it had been very hot and most medicines should be stored at or below 25c. If the temperature exceeds that temperature it could affect the effectiveness of the cream, which could lead to skin breakdown.

The registered persons had not ensured risks to people were appropriately assessed and managed to keep people safe. The registered persons had not ensured the safe management of medicines. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People received their medicines as prescribed and records were completed adequately. This included medicines which were administered on a 'when required' basis, for example pain relief. Protocols were in place to provide information to staff on how and when these medicines were administered.

● Registered nurses administered medicines to people. Their competencies were assessed annually in line with the providers policy.

Staffing and recruitment

● People told us they often waited for personal care. On the day of our inspection, one person became distressed. They had been promised they would receive their personal care and be in the lounge for a certain time each day. They told us, "I wanted to be down by 11am, but I was told it wasn't possible and I need to wait till half 11. This doesn't always happen, if you weren't here today I wouldn't have made it downstairs in time."

● People told us they felt staffing was an issue. One person told us, "Sometimes I feel like there could be more staff, sometimes the buzzer will go for a long time then the staff say they are busy. At the weekends especially we have more agency (staff). This does upset me, I prefer our own girls (staff)." Another person said, "I don't come down at the weekends, [staff name] isn't here at the weekends doing activities so I just sit in my room and watch TV. No one is in the lounge at the weekends."

● Relatives we spoke with also made comments about staffing levels and high use of agency staff. When asked if they felt their relative was safe, one relative told us; "We do not. Our concerns in this area lie with the ongoing under staffing issues which result in carers struggling to answer buzzers promptly."

● A system was not in place to monitor call bell response times. This meant the manager could not monitor how long it was taking for bells to be responded to, in order to assess staffing levels. One member of staff we spoke to said, "Sometimes bells take a while to get answered as in some rooms you cannot hear if the bell goes off."

● The manager and provider told us they were in the process of reviewing staffing levels. They used a dependency tool to calculate how many staff were needed. However, this did not take into account the complex layout of the building. During our inspection we observed people took a long time to make it down to the lounge. This meant people missed out on participating in activities that were on.

●Two people had fallen regularly in their rooms and these falls had been unwitnessed. Audits had identified that regular checks on people had not been consistent.

The registered persons had failed to consistently deploy sufficient numbers of suitably competent, skilled staff to meet people's needs. This was a breach of regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We reviewed staff recruitment records and found staff had been recruited safely. The provider had reviewed gaps in work history and sought references for staff from previous employers. Disclosure and Barring service (DBS) checks had been completed which helped prevent unsuitable staff from working with vulnerable people.

Systems and processes to safeguard people from the risk of abuse
● We discussed with the manager the process of reporting safeguarding concerns, as they had not always reported concerns in a timely way. This meant investigations to protect people were delayed which put them at risk of continued harm of abuse.
● People we spoke with said they felt safe. One person said, "Yeah I feel safe here, if I didn't, I would talk to the girls (staff)."
● Safeguarding policies were in place to protect people and staff had received safeguarding training. Staff we spoke to were able to identify potential signs of abuse and who to report concerns to.

Preventing and controlling infection
● The service was clean and odour free. There was enough domestic staff to ensure the cleanliness of the service was maintained.
● Some staff had received training in infection control. They had also received additional PPE (personal protective equipment) training due to COVID 19. We observed staff wearing appropriate PPE and there were stations around the home where staff could take off and put on PPE when required.
● The provider had implemented checks to keep people safe from the risk of COVID-19. For example, people's temperatures were taken on arrival, and anyone entering the service was asked to use PPE.
● People had been supported to see their loved ones. For example, people were able to have socially distanced visits within the garden of the service.
● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

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.

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

- Regulatory requirements were not always met. The provider had failed to notify CQC of a safeguarding incident that occurred. The manager sent this to CQC following the inspection.
- The manager had been open and honest about the issues that remained within the service, for example the need to complete staff supervisions and checking staff competency They had an 'open door' policy for people and staff. They encouraged concerns and issues to be raised so they could be investigated. The manager had been in regular contact with CQC and the local authority during the pandemic about how they were managing.

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

- Daily walk rounds had been started however, these had not identified the shortfalls found at this inspection. The daily checks had not identified thickening powder was not being stored safely, and creams were not being stored correctly in people's rooms.
- There were systems in place to monitor and check the quality of the service. However, these had not been effective in identifying issues we found on our inspection. Accident and incident analysis did not identify any potential patterns relating to staffing levels and risks to the environment such as hot water and fire were not addressed.
- The manager understood the improvements that needed to be made, they were working towards completing a development plan. The provider had completed quality assurance visits to check the progress and validate when actions were completed. However, these checks did not identify shortfalls we found.

The registered persons quality assurance processes had failed to identify issues relating to the quality and safety of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Changes in the management of the service meant progress had been made but there was still more to do. The improvements that had been made had not been embedded within the service including the monitoring and spot checking of daily charts to make sure they are accurate.

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

● Resident meetings were held regularly for people to get their views and opinions. On the day of inspection, we observed the residents meeting taking place. Some people that are unable to attend the meetings still get the opportunity to feedback.

● People were asked about what activities they would like to do. They were asked for their opinions on the quality of the food and housekeeping at each meeting people were happy with both.

● Feedback surveys were sent out to relatives last year however, none had been returned. The manager informed us they would be resending them this year. Relative meetings had not been held since the pandemic as no visitors had been allowed to reduce risks to people.

● Regular staff meetings were held, these were used to keep staff informed of changes within the service. Staff were supported to raise any concerns they may have. In May staff felt they had not been supported and morale was low. Improvements had been made and staff we spoke to were positive about the morale levels and support from the new manager.

● People and staff were united in their feedback of the manager and told us there was improvements since they had started.

Working in partnership with others

● The staff and manager worked with a range of health care professionals to provide joined up care for people. For example, people were referred to the SALT team (speech and language therapists) and dieticians when required. The staff continued to work in partnership with these agencies to ensure guidance was followed.

● The manager engaged with other local providers. For example, the local hospice team provided support and additional training for staff during the pandemic.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had not ensured risks to people were appropriately assessed and managed to keep people safe. The registered persons had not ensured the safe management of medicines. This is a breach of regulation 12 (2)(b)(g) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons quality assurance processes had failed to identify issues relating to the quality and safety of the service. This was a breach of regulation 17(2)(a) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons had failed to consistently deploy sufficient numbers of suitably competent and skilled staff to meet people's needs.

This was a breach of regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014