Bingley Wingfield Care Limited

Bingley Wingfield Nursing Home

Inspection report

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Date of inspection visit:
14 January 2021
15 January 2021
18 January 2021
20 January 2021

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Bingley Wingfield Nursing Home is a care home providing personal and nursing care to older people and people living with dementia, a mental health condition and physical disability. The service accommodates up to 44 people in one adapted building. At the time of the inspection 26 people were using the service.

People's experience of using this service and what we found
People were not safe. Risks to individuals were not appropriately assessed and managed. Medicines were not managed safely. Systems for recording and monitoring accidents and incidents were unsafe. Lessons were not always learned when things went wrong. There were sufficient staff to keep people safe but sometimes people had to wait for support. A member of staff said, "Residents are looked after but they could be looked after better with more staff, it is draining." The provider was signposted so they could develop their approach to infection prevention and control.

Staff were recruited safely. The management team understood how to report safeguarding concerns and the staff team were all familiar with the whistle-blowing procedure.

The provider's quality management systems were not effective and did not identify areas where the service needed to improve. The manager who had only been in post for four weeks had started to make changes. Overall, people who used the service, relatives and staff provided positive feedback about their experience. The management team were responsive to the inspection findings and shared plans to improve their systems and processes.

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 13 August 2018).

Why we inspected
We received concerns in relation to medicines, staffing and management of risk. 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. 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 inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe 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 Bingley Wingfield 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 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 assessing and managing risks to individuals and governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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.

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

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Bingley Wingfield 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
Two inspectors and an Expert by Experience carried out the inspection. 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
Bingley Wingfield 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 manager commenced four weeks before the inspection and said they would be submitting an application to register. This means, once registered, 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
We gave short notice that we would be making phone calls to people who used the service, their relatives

and staff. This was so their permission could be sought before we made the phone calls.

The site visit to the service was unannounced. Inspection activity started on 14 January 2021 and finished on 20 January 2021. We visited the service on 18 January 2021.

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, Healthwatch and professionals who work with the service. This information helps support our inspections. We used all of this information to plan our inspection. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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
We spoke with seven people who used the service and seven relatives about their experience of the care provided. We spoke with eight members of staff including the manager, deputy manager, senior care worker, care workers, chef and the nominated individual. Discussions with people who used the service, relatives and staff were conducted either on site or via telephone calls. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment. 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 manager and nominated individual to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

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

Using medicines safely

● Medicines were not always managed safely. Medicine administration records (MARs) had gaps where there were no signatures to show medicines had been given or codes used to explain the reason for omission. This meant we could not establish if people had received their medicines.

● People did not always receive their medicines at the right times. We observed morning medication was still being administered at 1pm, although this was not reflected on the MARs. The nurse told us they normally finished the morning medicine round at 12.30pm.

● The service did not have appropriate guidance for staff to follow when people were prescribed 'as required' medicines. Where protocols were in place these were not accurate, person-centred or up to date.

● People did not always have administration records for prescribed creams and there was no information for staff about how, when and where to apply topical creams.

● One person was prescribed a thickening agent to be added to drinks to minimise the risks of choking. The administration record had not been signed and there was no information to show the amount of thickener to be used.

● One person received their medicines covertly (hidden in food or drink). A best interest process was recorded for this decision which stated the decision would be reviewed monthly. There was no evidence of review and no mental capacity assessment had been completed prior to the best interest decision.

● Although staff who administered medicines had completed medicines training, they had not had their competency assessed.

Medicine management systems were not always safe which place people were placed at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored safely and securely and at the correct temperature.

● Safe systems were in place for the ordering, receipt and disposal of medicines, including controlled drugs

Assessing risk, safety monitoring and management

● Risks to people were not assessed and managed safely. Assessments did not identify potential risks. For example, one person's assessment did not accurately describe the condition of their skin. The person had wounds to both legs, but staff had not clearly recorded the care they had delivered to try and aid healing.

● People's safety was not appropriately monitored. For example, daily records showed one person had put another person at risk 13 days before the inspection. The management team were unaware of the incident.

● Staff did not always follow guidance for managing risk. For example, one person had frequently displayed

behaviours which may challenge. The person's care plan stated how they should be supported. However, the care records were brief and did not evidence the person received the right support.

The provider failed to assess or manage risks associated with people's care. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Accidents and incidents were not appropriately monitored. Staff did not always complete appropriate forms and records were brief, for example, in relation to one person staff recorded, 'physically violent towards staff' and 'very angry today'. This meant the management team could not review what had happened and decide if new approaches were required.
● The provider's system for identifying patterns and trends in relation to incidents was not effective. A monthly analysis was completed but not all events were included. This meant the lack of learning from incidents and reducing the risk of repeat events put people at risk.

The lack of learning lessons and improving care meant people were at risk of receiving poor quality care. This was a breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager had identified the accident and incident system was not robust and had started to strengthen the process.
● The provider shared examples where they had learned lessons and improved systems such as monitoring people's weight.

Staffing and recruitment
● There were enough staff to keep people safe although they sometimes had to wait to receive support. Feedback about staffing levels varied; some people felt staffing arrangements were appropriate, but others said staff were too busy. One person said, "They are overworked, I do honestly feel they could do with more staff." A member of staff said, "Residents are looked after but they could be looked after better with more staff, it is draining."
● The manager was reviewing staffing arrangements to ensure all staff were deployed effectively. For example, organising additional support to administer medicines.
● The provider recruited staff safely. They carried out appropriate checks to make sure staff were suitable before they started working at the service.

Systems and processes to safeguard people from the risk of abuse
● People felt safe. Everyone provided positive feedback about the staff and management team.
● The management team understood their responsibility to protect people from abuse. The manager and nominated individual understood safeguarding reporting procedures.
● Staff had completed safeguarding training and were familiar with the whistle-blowing procedure. They knew to report all concerns to the management team although this had not been consistently followed in practice. The manager had started working with the team to ensure reporting procedures improved.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● 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 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.
We have also signposted the provider to resources to develop their approach.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

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

- Significant shortfalls were identified at the inspection. The provider was in breach of two regulations across two key questions; the service has been rated inadequate overall and placed in special measures.
- Systems and processes for monitoring quality and safety were not implemented effectively. The management team carried out a range of audits, but these did not always highlight issues and drive improvement. For example, a medicine audit completed by the provider in November 2020 did not identify shortfalls found at the inspection.
- Potential organisational risks were not always understood and managed. The service did not follow safe infection prevention practice guidance. For example, the environment was cluttered which meant cleaning was difficult and people did not always social distance. The management team acted when this was brought to their attention.
- The management team did not have a clear overview of what was happening in some aspects of the service. They did not know how many accidents and incidents had occurred because staff were not consistently recording and reporting incidents. For example, ten incidents were recorded in one person's daily notes in January 2021 but only two incident forms were completed; this had not been picked up through the provider's governance system.
- Systems did not ensure the delivery of care was high quality. Inspectors were told three people were isolating in their room, but this was unnecessary as their isolation period had ended three days earlier; staff on duty during the site visit were unaware which meant this had not been communicated throughout the staff team. Some people were not having regular baths or showers, but this had not been picked up through the monitoring processes.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider had notified us about several significant events. However, they did not always do this correctly. For example, the provider did not tell us until January 2021 about an event that happened in November 2020.

The lack of robust quality assurance meant people were at risk of receiving poor quality care. This was a breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service did not have a manager registered with CQC. A new manager commenced four weeks before the inspection and told us they would be submitting an application to CQC. The nominated individual had been based at the service five days a week to support the management team.
●The provider had introduced an electronic system to help improve care recording.
● The management team responded after the inspection and told us they were keen to improve their quality management systems. The manager shared information about systems they were introducing to improve how they identified, monitored and managed quality and safety. These showed they were taking appropriate measures to address the shortfalls.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People who used the service and relative's feedback about Bingley Wingfield Nursing Home was generally positive. Overall, they told us they were satisfied with the quality of the service and were complimentary about the staff who supported them. Comments included, "They smile when they come in and have a good work ethic, they are nice but don't have chance to talk", "Think there is enough to do and I mix with the other residents and the food is good, I like the staff and we get on well" and "Any concerns they always ring me, they keep in touch, they never make me feel a nuisance."
● Staff had opportunities to share their views and felt supported in their role. Meetings were held on a regular basis and planned throughout 2021. Staff said the management team were visible and approachable.
● The service was strengthening quality assurance processes. Surveys covering areas such as laundry, activities and food, had been carried out with people who used the service in January 2021; these responses were being collated. Further surveys for staff and relatives were planned for February and March 2021.

Working in partnership with others
● The provider worked alongside other professionals and agencies.
● The local authority told us the management team at Bingley Wingfield Nursing Home has worked professionally with the commissioning and safeguarding team.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicine management systems were not always safe which place people were placed at risk of harm. The provider failed to assess or manage risks associated with people's care.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of learning and improving care meant people were at risk of receiving poor quality care. The lack of robust quality assurance meant people were at risk of receiving poor quality care.

The enforcement action we took:

Warning notice