Community Integrated Care

Winsford Grange Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place over three days on the 23, 24 and 25 May 2018, the first day was unannounced and the other two days were announced.

At the last inspection on the 24 and 25 March 2015 the service was rated as good. We did however ask the provider to take action to make improvements in relation to capacity and consent. We found at this inspection that the required improvements had been made.
During this inspection we found multiple beaches of the Regulations in regards to safe care and treatment, personalised care, dignity and respect, record keeping and good governance.

Winsford Grange Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Winsford Grange accommodates up to 60 people in one building across three separate units, each of which have separate adapted facilities. At the time of the inspection 57 people were living at the service.

The service has a registered manager. 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.

Management of medicines was not safe. Medication was not checked to ensure that it was in date and stored correctly. Adequate information was not available to staff to ensure that medication was correctly administered.

Where risks to health and welfare were identified, robust risk assessment and management plan were not always in place to assist staff in minimising the risk of future harm. Equipment used to manage the risk of developing pressure ulcers was not checked to ensure it was set correctly.

Care plans were in place which aimed to assist staff in providing the correct level of care and support to a person. These however were not accurate or up-to-date. This meant that there was a risk that staff less familiar with the person may not provide the right level of care treatment. Other records, used to evidence care provided were incomplete. Therefore, we could not ascertain whether people had received care and support to meet their needs.

People who used the service and their relatives described it as being "unsafe" due to their concerns about staffing levels. People did not receive their care in line with the needs and wishes. At other times, a person's dignity or respect was compromised due to interventions or lack of response by staff. The register provider could not demonstrate that staffing levels were sufficient to meet people's needs.

There was a lack of stimulation and social engagement for people throughout the day. People and relatives commented that there were long periods of the day with nothing to do. We made a recommendation that the registered provider undertake a review of activities to reflect the needs of people at the service and best practice guidelines.

The systems in place to monitor the quality and safety of the service were ineffective. Where issues had been identified action had not been taken by the register provider to make positive changes in a timely manner. Audits undertaken by the registered provider failed to highlight a number of concerns which we found at this inspection.

People received meals that were nutritionally balanced. However, people felt that there was a lack of choice in regards to their meals. We observed that some people went a long period without food or drink. Staff did not keep accurate records detailing what a person ate or drank throughout the day which meant there was no guarantee that people had been provided with the food and drink they needed to keep them healthy and well.

Staff had an awareness of the Mental Capacity Act and how it impacted on their work. They knew that sometimes they were required to make decisions in a person's "best interest". Mental capacity assessments had been undertaken and where appropriate best interest decisions which were made on behalf of people were documented. Where restrictions have been placed upon a person's liberty, the deprivation of liberty safeguards had been requested. Staff were aware of what this meant for the person in regards to their care.

People complimented staff that provided their support and told us that they were kind, caring and very hard-working. People capable in the latter days of their lives and relatives commented that this was done with dignity and respect. Staff worked closely with colleagues such as district nurses, dieticians, tissue viability nurses and social work staff in order to meet people's end of life needs and wishes.

Staff underwent induction training and received on-going training in relevant to their job role. Staff were encouraged to take on new roles and responsibilities. People felt confident that the staff caring for them have the right skills and knowledge to do so safely. Staff had not received a one-to-one supervision in line with a registered provider's policy, however this was being addressed.

Staff had an understanding about safeguarding people and keeping them safe. Concerns reported to the management, to the local authority and the CQC where appropriate. Staff did not always feel able to raise concerns with the management team and a consequence a number of whistleblowing concerns had been raised with the CQC.

The service is advertised as a dementia specialist service. We found that the environment was not dementia friendly and not sufficient adaption had been made to aid and support people who are living with dementia.

Checks were undertaken to monitor the safety of the premises. This included ensuring that utilities such as gas, electricity, water, electrical equipment were serviced checked and repaired. A fire risk assessment had recently been updated and identified a number of areas required in order to keep people safe. A remedial action plan had been developed to monitor the required changes.

Processes were in place to ensure that staff recruited were of suitable character and skilled for the job role. The required pre-employment checks had been carried prior to each member of staff starting work at the service.

There was a complaints process in place which people were aware of. However, only written complaints were treated formally, logged and responded to. Some people felt that their verbal complaints not listened to and acted upon. We made a recommendation that the registered provider review how they record and respond to all complaints.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Not all risks had been assessed and planned for to minimise the risk of harm to people.

Observations and feedback from people indicated that there were not always sufficient numbers of staff on duty to meet people's needs.

The management of medication was unsafe putting people at risk of harm.

Safe staff recruitment procedures were followed. Staff were knowledgeable about safeguarding processes and appropriate referrals had been made.

Is the service effective?

Requires Improvement

The service was not effective.

Not all staff received regular supervision or an annual appraisal to support them in their role. Appropriate training was regularly available to staff.

Appropriate referrals were made to external health care professionals to maintain people's health and wellbeing but their advice was not clearly documented for staff to follow.

People's nutritional needs were not always monitored, assessed or met effectively.

Applications to deprive people of their liberty had been made appropriately and consent had been sought in line with the principles of the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not caring.

Staff were kind and caring and mostly treated people with respect. Staff knew people they were caring for well, including

their needs and preferences. However, support was hurried and did not always meet people needs.

People dignity was compromised due to an inefficient laundry service.

People and their relatives were involved in care planning.

There were no restrictions in visiting and relatives told us they felt welcome and supported by the staff.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not person centred and did not provide staff with the information they required to deliver care in line with a person's needs and wishes.

Documentation failed to provide evidence that care had been provided in line with support and treatment plans.

Formal complaints were responded to but people who had raised informal concerns felt that they did not always have a response.

Is the service well-led?

Inadequate

The service was not well led.

Checks undertaken failed to highlight or address concern in regards to the quality and safety of the service.

The registered provide had failed to display its rating on their website for the public to be aware of its performance.

The registered provider failed to notify the CQC of an incident at the service which had resulted in an injury to a person.

Meetings were held with people who used the service, relatives and staff. However, people did not feel listened to and commented that change was poorly communicated and managed.

Winsford Grange Care 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 checked 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 over three days on the 23, 24 and 25 May 2018, the first day was unannounced and the other two days were announced.

The inspection team consisted of an adult social care inspector, a specialist advisor who was a Nurse, and an 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.

Ahead of the inspection we reviewed information we had received about the service such as notifications of serious injury, safeguarding and complaints. We also received a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and any improvements they plan to make.

We also gathered the views of the Clinical Commissioning Group (CCG) and the local authority commissioning and safeguarding teams. We also spoke with a number of social workers, the Infection Prevention and Control Team and reviewed the recent Health Watch report.

We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke to twelve people who used the service, eleven of their relatives and fifteen staff. We also met with the registered manager and members of the senior management team over the three days.

Throughout the inspection, we observed how staff supported people with their care during the day.

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 to us.

We also reviewed a selection of records from 15 care plans, four staff files, training records, ten Medication Administration Records (MARs) and records relating to the maintenance and governance of the service.

Inadequate

Is the service safe?

Our findings

There were policies and procedures in place to support staff in the safe management of medicines but these were not always followed.

Some practices were unsafe and posed a risk to people who used the service. The medication trolley was observed to be left unlocked and unattended on one of the units which meant that it could be accessed by people not authorised to do so. Spoons and syringes were being used more than once as were pill crushers. This meant that there was a risk of medication being passed from person to person. Following the inspection we were informed that single use equipment had been ordered for future use.

A number of homely remedies such as medication and dressings used as were out of date. A homely remedy is another name for a non-prescription medicine that is available over the counter in community pharmacies. They can be used for the short-term management of minor, self-limiting conditions. In April 2018 a person had been administered medication that had expired in January 2018. Other prescribed medicines such as eye drops were in use but staff had not always recorded when they were opened and therefore due to be disposed. There is a risk that the effectiveness of a drug may decrease over time past expiry. Following the inspection, we were informed that these were taken out of use and the use of homely remedies was to be reviewed.

The rooms in which medicines were stored were not clean and there was an excess supply of medicines. The rooms had not been checked daily ensure they remained at a suitable temperature. Fridges were provided but they contained some medicines that did not require cold storage. The maximum and minimum temperatures for the fridge's were not carried out daily and recorded as required. This meant that there was no guarantee that medicines were stored at the correct temperature and that they were fully effective.

Some people had medicines that were given 'as required' (PRN) such as for pain relief or the management of agitation. Whilst, there were care plans in place for their use, some had not been reviewed since 2014 and others were not detailed enough to ensure that people received these in a consistent manner. For example: a person had been prescribed medication that had a calming effect but the instructions for staff were to administer when 'anxious or agitated'. Subsequent to the inspection, we were sent a number of PRN care plans that had been reviewed in order to better inform staff about the use of them.

On occasion, people needed to have their medicines given covertly (hidden or disguised). There was no risk assessment in place to consider whether the person needed to take them and no instructions for staff as to how to correctly administer the medication. There was no evidence that the route of administration had been discussed with a pharmacist. For example whether the medication should be crushed and added to food or drink. This meant that staff may not give the medication in the correct way and its effectiveness may not be maintained.

Accurate records were not kept where topical creams or pain relieving patches had been prescribed for people. For example: one person required a pain relieving gel three times each day but the topical

medication administration record (TMAR) indicated that it was applied ten times in January 2018, seven times in February 2018, four times in March 2018, twice in April 2018 and only once in May 2018. Body maps were in place to assist staff in applying pain patches but they failed to indicate to staff how and where they were to be applied. A pain relieving patch had been applied in the same position on one person's body on consecutive occasions which was contrary to guidelines. We asked the Nurse they informed us that this was not the case but they not recorded it correctly. The lack of accurate MARs meant that there was no guarantee that people had received their prescribed medication as required.

Some people had specific needs for which it was necessary to carry out an assessment of risk and how best to minimise the risk of harm. These assessments were not always in place, others had not been reviewed whilst some had not been followed. For example: A number of people had mental health issues or behaviours that challenged, however there was no risk management plan for staff less familiar with the person to follow. This meant that staff may not provide support in a way that was safe or met the person's needs.

We saw that risks had been identified for a person whilst they were transferred by the use of a hoist. The person had on occasions tried to get their arms over the hoist which was potentially unsafe for the person. However, no risk management strategies had been considered to minimise the risk of harm to the person whilst using the hoist, instead the decision had been made to support that person in bed. No consideration had been given to the restrictive nature of this practice.

One person was in bed and lying on their catheter bag as it had come detached from their leg. There was no evidence that they had been checked by staff that morning with the last recorded check at 05.30 am. From 8.30 am to 11.43 am we had to request three times before staff attended to this as they were busy with others. This meant that staff had not recognised or responded quickly to the potential health risks associated with urine not flowing freely though a catheter.

One person had been assessed as requiring one to one care due to risks associated with their behaviours. The support was provided by an agency worker who had not arrived on the morning shift at 10am as required. Staff failed to bring this to the attention of the registered manager until 11.10 during which time the persons was at risk of harm as they were not properly supervised.

One person had skin damage caused through friction and repeated movement. However there was no risk assessment or management plan in place to demonstrate what actions had been taken or in place to avoid this from reoccurring even though it had been an issue since March 2017. The latest wound being documented 16 March 2018. Daily records sated that there was excessive movements causing friction wounds and that staff were to monitor.

There had been a reduction in housekeeping staff since January 2018. People who used the service, family members and staff informed us that this had impacted on the service in that it was no longer clean and there was a delay in laundry being done.

Our observations confirmed that the service was visibly unclean in some parts with dirt, debris and dust. For example: some people's beds and not been cleaned underneath for some time, bedrail protectors were dirty as were overlap tables. A fridge, used for the storage of medicines was dirty and had mould growing inside it. Staff informed us it was no longer in use but it had not been removed and posed a risk of cross contamination when opened. Equipment, such as wheelchairs, were stored around the service but were dirty and communal toiletries were found in bathrooms. The Infection Prevention and Control Team also had expressed concerns over the management of an outbreak earlier in the year. This meant that there were

inadequate measures in place for the prevention and control of infections.

There were no regular Health and Safety (H&S) checks carried out throughout the service apart from the annual H&S audit. This meant that issues such as dirty or broken equipment, cleanliness, inappropriate storage, unlocked rooms containing cleaning products, were not highlighted and immediately addressed, which put people's safety at risk.

A number of people had been provided with pressure relieving mattresses to assist in the prevention or deterioration of pressure ulcers. There was a lack of information available to staff to assist them in checking that these were set correctly. There was a risk of harm should these be set at a pressure too hard or soft for the persons weight. Following the inspection, we were informed that new processes had been put in place to ensure that this equipment was checked as required.

These are a breach of Regulation 12 of the Health and Social Care Act 2018 (Regulated Activity) Regulations 2014.

Prior to the inspection, CQC had received a number of concerns in regards to the staffing levels and deployment of staff across the service. All of the staff, relatives and people who used the service expressed concern that there were times of the day and night when, in their opinion, there were not enough staff to keep people safe or to meet their needs. Comments from people who used the serve and families included There are never enough staff, you just have to wait your turn", " The staff are run ragged around here, I feel so sorry for them" and" My relative would like to bath more often but there just aren't the staff available anymore". Staff told us " We want to do a good job but we don't have the time and its upsetting that we cant provide good care ". Our observations confirmed that some people had to wait to receive their care or were left in situations that compromised their safety. This is further reflected in the caring domain of this report.

We looked at rotas for the staff and found that there was no consistency in the staffing hours allocated on each unit throughout the week. There was also a significant amount of time allocated to Agency staff. Staff commented " We don't know from one day to the next who is going to turn up on shift" and " They expect us to work across the Units but there is no direction and you inevitably then leave another unit short". For example: on some days there were three care staff from 8 am to 2 pm whilst on other days there were only two staff on duty. In the afternoon, there were only two care staff on each unit but there was no clear rationale as to why this was reduced as some people required the assistance of two or more care staff with all personal care needs. Staff told us that late afternoon time, especially on the unit for those people living with dementia was just as busy as people tended to display behaviours associated with 'sun downing'. This is also known as "late-day confusion" where agitation and walking about may get more pronounced in the late afternoon and evening.

The registered provider used a dependency tool to assess the number of staff required. We reviewed the dependency tool and noted that it gave an allocation of staff hours to each person ranging from two to four hours over a 24 hour period. This did not take account of people's personal choice or routines. One person was allocated four hours each day but staff informed us that it could take two or three staff up to 30 minutes at any one time to provide the person's support throughout the day. Staff commented " This daily allocation is not sufficient as it barely covers the basics" and " There is no scope for personalised care with the hours each person has". We saw that nine of thirteen people required assistance with food which meant that the last person was still being assisted at 13.45 which was not their personal choice.

The service provided support for people coming out of hospital in what was called the 'discharge to assess'

scheme. Staff expressed concern that the increase in admissions and discharges at the service coupled with the fluctuating or rehabilitation needs of this group of people had not been considered in terms of the impact on staff time.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The registered provider told us that they believed that the staffing levels were adequate for the service and that it was the deployment of staff that required further review and consideration.

We looked at accident and incident reporting within the service and found that they were recorded and reported appropriately. The report detailed how, when and where the accident happened, the type of injury and any actions taken following the accident.

Maintenance checks were carried out on the building to ensure that it was safe. These included checks on electrical items, the gas and electrical system, lighting, water, hoists and fire equipment. A Fire Risk Assessment had been carried out in March 2018 and a number of improvements were documented in a report to the registered provider on the 14 May 2018. An action plan was in the process of being completed to address these issues such as the completion of simulated evacuation drills, a review of the evacuation plan and repairs to the building to prevent the spread of fire.

Staff were aware about adult safeguarding, what constitutes abuse and how to report any concerns. Staff were knowledgeable about safeguarding processes and most had completed training. A safeguarding policy was in place to help guide staff and contact details for the local safeguarding teams were available within the home. We found that appropriate referrals had been made to the local authority and the registered manager maintained a log of all referrals made. The registered provider also had a whistleblowing policy in place which encouraged staff to raise any concerns without fear of repercussions. A number of anonymous concerns had been directly raised with CQC leading up the inspection.

An equal opportunities policy was also available within the service. This helped to raise staff awareness and ensure that people were not discriminated against regardless of their age, sex, disability, gender reassignment, marital status, race, religion or belief or pregnancy, as required under the Equality Act 2010. The registered manager told us there was nobody living in the home at the time of the inspection that required personalised support in relation to any of the protected characteristics.

The registered provider had systems in place to ensure that staff recruited were of suitable character. Staff completed an application form and then underwent an interview that addressed the key requirements for the role. References were taken up and verified. Staff also had a Disclosure and Barring check to ensure that they had no convictions or cautions that could deem them to be unsuitable for work in social care.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in August 2015, we found there to be a breach of Regulation 11 due to a lack of consideration of the Mental Capacity Act 2005. At this inspection we found that the required improvements had been made.

The Mental Capacity Act 2005 (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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

A number of applications to deprive people of their liberty had been made and a small number had been authorised. Staff were aware of who had an authorisation in place. A log was maintained which detailed all applications made, date of expiry and date renewal forms had been submitted. DoLS applications had been made appropriately for people.

Staff had a good understanding of the MCA, they told us they always asked for people's consent before providing care and we observed this during the inspection visit. For instance, we saw staff knocking on people's doors before entering and we heard staff asking for consent before providing care. When people were unable to provide valid consent due to cognitive impairment and memory difficulties a mental capacity assessment had been completed to establish whether they were able to make an informed specific decision. Where a person had been assessed as lacking capacity regarding a particular decision, a best interest decision was recorded that involved the views of relevant people as required. We found that consent was gained in line with the principles of the MCA. For example: this was evident where people had medication given covertly or where they had bed rails in place.

People had mixed views about the meals that they received .The registered provider used a pre-prepared meal service which consisted of a four weekly menu for lunch and dinner. These meals were nutritionally balanced and also catered for special dietary requirements.

Where concerns had been highlighted in regards to a person's dietary or fluid intake, staff were required to keep an accurate record of consultation in order to inform any treatment plan. However, we found that these records were not accurate or completed in a timely manner. They were not reviewed by a member of the nursing team in order to highlight or address concerns. For example: the records for one person indicated that over 24 hours they had breakfast, lunch and 600 mls of fluid. The last recorded drink was at 12 mid-day. We observed staff at lunch time trying to recall with some difficulty what people had consumed that morning. Therefore there was no assurance that people's nutritional and hydration needs had been met.

We observed, and records confirmed, that staff often bypassed people when offering food and drinks if they were sleeping or dozing. This meant that people could go longer periods without food and fluids. For example : records for a person indicated that on one day they were sleeping at 9 am, 11 am and 8 pm when drinks and meals were offered. There was a record which showed that the person had drunk 600ml of fluid that day. The last recorded drink was at 16.00 and the last food at 16.30. There was no record then until 9 am the following day. We met a person who was in bed at 10.30 am; they asked us "Can I have a drink please; please can I have a drink". We observed that their lips were cracked and their mouth was dry. We asked staff to support the person to have a drink and the person gulped down a drink quickly, expressing a thirst. The person's records showed they had missed drinks and food the evening before as they were sleeping. There were not adequate steps in place to ensure that nutritional and hydration intake was monitored and recorded or that people were offered things at different times if they were absent or sleeping.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their representatives told us that they felt confident that the staff had the skills and knowledge to care for them effectively. One comment in a compliment letter stated, "The skills in caring and taking the time to know [names] needs were just exceptional".

Staff received an induction at the start of their employment that was both theory and practice. Staff completed the Care Certificate which is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.

Staff had the opportunity for on-going training and development. We looked at the training that the registered provider deemed as 'essential' and found that 93% of staff had completed Fire Training, 87% First Aid, 74% Moving and Handing , 81% Managing Challenging Behaviours and 87% safeguarding. The registered manager informed us that some of the figures were lower as it included staff who were on long term absences and so not available for training. Staff had not received supervision in line with the expectations of the registered provider but these were now planned in.

Care files we viewed contained plans which offered the opportunity to assess people's physical and mental health, as well as their social needs. However, we found that the majority of these did not add meaningful personal information to the prescribed text within each of the documents. The registered provider informed us that they were in the process of trialling, at other services, a computer based care plan system that aimed to make care plans much more person centred. This would be rolled out to all their services in the next few months.

People at the home were also supported by other external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the mental health team, tissue viability nurses dietician and social workers. Advice was not always then incorporated with the person's care plan for staff to follow. A GP also visited to review people and discuss any concerns the staff had regarding people's health and wellbeing.

The building had been designed to meet the physical needs of people living in the service. There were wide spacious corridors with handrails to support people with mobility issues. There was space both inside and outside where people could spend time on their own or with family if they chose to. The registered provider identifies the service as a dementia specialist service provision. During our inspection we found that the environment was not completely dementia friendly. We saw no evidence of any items of interaction or

stimulus in the environment which could be used to support
reminiscence and way finding such as memory boxes, pictures of the local areas and favourite pastimes of people supported. There were no items of familiarity in place to support people living with dementia to understand what a room, cupboard or space was used for. This meant that people were at risk of increased confusion and distress and their independence being
limited as the environment did not specifically cater for their diagnosis.

We recommend the registered provider refer to best practice guidelines and consider changes to support the needs of people living with dementia.

Requires Improvement

Is the service caring?

Our findings

People confirmed that staff were caring and tried to offer them choices and respect their wishes. However one person told us "In reality there was sometimes little choice as there was not enough staff". Other comments included "Yes I can decide, it's just staffing, for example, if I want to get up I have to wait my turn", "Yes I can ask to go to bed when I want to but it depends on how busy they are" and "I'm asked if I want a bath but it's only once a week though. I would like one more often but the staff are too busy". Another relative shared a similar concern stating that "[relative] would like a bath more often, it helps their arthritis. There just isn't the staff".

One relative said that they had seen a difference in the support over the last few months and stated "It's not as good as it used to be. No one seems to be listening. My [relative] needs support with everything but she has to wait her turn". They told us that their relative liked their teeth cleaning after her meal: sometimes they have to wait or sometimes it doesn't get done. We observed this at this inspection when the person asked staff to clean their teeth. Staff said, as soon as I can get round to it I will do them for you. We checked at the end of the day and it had not been done.

People said that staff never had the time to really listen to them and chat as they were too busy providing support. One person, who had few visitors said, "It's not their fault if they can't listen to me, they don't have time." Other people expressed concern that they could not always communicate effectively with some of the staff who did not have English as a first language. One person commented "They don't understand me. I give up in the end. I've told staff about some things, like the night staff not understanding me. But they say no one is listening".

Staff told us that they felt disappointed that they could not offer choice due to the staffing levels. One told us "We have to work the best we can; people have to wait for us and that upsets me".

People had a choice of two main meals, however a number of people commented on the lack of choice. Comments included: "Sometimes they have run out of your first choice and then it's no choice". Another person said that during the hot weather they did not want a warm meal but there was no option for a salad or snack. Minutes of a meeting held in April 2018 indicated that people had been informed that "CQC have demanded we have clear contents evidence of food" whilst this was the registered providers decision.

This is a breach of Regulation 9 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not everyone had open access to areas of the home. Some bedroom doors and bathroom were locked but there was no rationale to why this restriction was in place and no evidence of people's consultation or consent. We found that not all staff was able to open a bedroom door and so this meant that people could not easily access their own private space.

People's dignity was not always respected. One person was in the lounge at lunchtime wearing pyjama

bottoms. Staff told us that this was because they had no clean trousers to wear. A relative also told us that on occasion "My [relative] has recently not been dressed due to clothes not being washed". Staff informed us that laundry hours had been reduced and this particularly affected the weekends. They told us that we "Prioritise between sheets or clothes on occasions".

The language used to describe people in their records required review as it did not always afford a person respect. We found that words such as 'obstinate' and 'stubborn' were used. We also overheard staff speaking loudly across the room about matters personal to a person: for example one staff member called to another "[name] has done one on the toilet and has also had a wee".

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Equipment was in use when people needed it to help maximise their independence. This included the use of walking frames, wheelchairs, bath hoists and electric beds. One person used a beaker with a lid and handle to drink from to enable them to continue to drink independently. Others used special plates and bowls that assisted them to achieve more independence. However, two people commented to us that they were given adapted utensils when they did not want or need them. One person told us "I always get plastic stuff but I am not a child and want glass or china". Their relative had brought things in for then but commented that they went missing or broken in the wash.

We looked at the service user guide and statement of purpose which were available within the home. These contained information about the service and what could be expected when a person moved in. It also included information regarding the complaints and safeguarding processes. This showed that people were given information and explanations regarding the service.

We observed relatives visiting throughout both days of the inspection. The staff told us there were no restrictions in visiting and relatives we spoke with agreed. This helped people to maintain relationships made prior to moving into the home and prevent isolation.

There was an awareness of the advocacy services if a person did not have friends or family to support them, but that nobody living in the home required these services at the time of the inspection. An advocate is a person that helps an individual to express their views and wishes, and help them stand up for their rights.

Inadequate

Is the service responsive?

Our findings

Each person had a series of care plans and risk assessments with the purpose of informing staff about the support and treatment they required. The care plans had pre-populated generic information but not all was of relevance to the person. These were not made person centred and did not fully address individual wishes, routines and preferences. For example: there was no information as to when a person liked to get up or go to bed or how they liked their care to be provided.

Evaluations of the care plans and daily records indicated that the support and treatment required was different to that in the care plan. This was because some care plans were over 12 months old and had not been updated when a person's needs had changed. For example: one care plan stated that a person had a 'good nutritional status, weight was acceptable and steady'. However, other records indicated that they had lost some weight, were less independent and needing close supervision and assistance at meal times. This meant that there was a risk that staff, less familiar, with a person may not provide them with the right level of support.

We had particular concerns in regards to the records relating to wounds. Where specialist advice had been given from Tissue Viability Nurses, this had not always been formulated into a clear wound treatment plan for the Nursing or care staff to follow. Records did not clearly indicate what was required for each wound in terms of treatment or dressing changes. This meant that there was a risk that people were not provided with the right treatment. We found that records did not evidence that dressings were changed in line with the required frequency.

In order to support the prevention of pressure ulcers , some people were to be repositioned at set intervals throughout the day but there was no evidence that this was being done. For example: the records for one person indicated they were repositioned at intervals ranging from seven to two hourly and another had a range of 1.5 to four hourly. The 'positional change' charts did not indicate to staff the frequency or position of turn required. This meant that there was a risk that a person may not be repositioned as required putting them at risk of developing pressure ulcers.

Technology was used within the service to help ensure people's safety and wellbeing. However, there was not always a record when call bells were not available in bedrooms, as to how people could summons or receive help when they needed it. As a result, there was a risk that people may not receive support in a timely manner.

Some people had communication difficulties by way of their physical or mental health but this had not been taken into account either within their care plans or the way that information was presented to them. For example: there were no picture menus to assist people in making a choice of meal.

This was a breach of Regulation 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Many of the people who used the service had complex health needs and were cared for until the end of their lives. Staff had the skills required to support people at this time and also worked together with community health professionals to make this possible. One relative had commended the staff's ability to support during a person's last days stating "If I had not found Winsford Grange, then [my relatives] final days would have been far more painful for us all".

There was an activity coordinator responsible for engaging people in activities both within the home but also in the community. We were informed that time was also spent on a one to one basis with people. People had little comment on what was on offer but some relatives commented that there were long periods of the day when there was a lack of stimulation and things to do. We did not observe any group activities over the time of the inspection.

We recommend that the service finds out more about meaningful activities for service users based current best practice, in relation to the specialist needs of people living with dementia.

There was a complaints policy and procedure for people who used the service, their representatives or other agencies to follow. Where formal complaints had been made, these were logged along with a response and an apology. There was no log kept of informal complaints or whistleblowing concerns that had been raised about the service. This meant that some people felt their concerns had not been addressed or responded to. One person told us, "I've raised concerns to staff about clothes going missing. We do the washing now as we couldn't keep up with the loss of them. I've not had any formal feedback about my complaint".

We recommend that the service review their processes to fully address the management of and learning from complaints.

Inadequate

Is the service well-led?

Our findings

Since the last inspection, there had been a number of management changes both locally and regionally which had affected the leadership of the service. CQC had not always been informed of these changes or the absence of a registered manager. We issued the registered provider with a Fixed Penalty Notice under our criminal powers which they accepted in regards to this matter.

There was a registered manager who commenced work at the service in the month leading up to the inspection. They had moved from another service operated by the registered provider.

Staff overwhelmingly told us that they did not feel valued or supported by their employer. Comments included "There is no point in speaking to anyone, we are not listened to" and "The vision for the service is not good at the moment. Staff are leaving due to what they expect of us. It's not safe, it's not right and people are not cared for correctly".

Meetings had been held with staff, people who used the service and their families to discuss matters of relevance to them. Topics of concern included staffing levels and proposed changes to staff. The registered provider was introducing a 'care practitioner 'role. This is founded on extra training for care workers, with the expectation that they will take on basic nursing tasks, freeing up registered nurses' time for higher-level work. They planned a reduction in the number of Nurses from four to two each day once these posts were in place which was causing some anxiety for staff, people who used the service and relatives.
Staff felt that change was not managed or communicated well which left them feeling disheartened and demotivated. A number of staff had left and others were considering leaving as a result. The registered provider was aware of this and conceded that information in regards to some matters had not been cascaded in the way that it had been intended.

The systems and processes in place to monitor the safety and effectiveness of the service were not effective and failed to highlight or address concerns.

The registered provider had a system in place by which a member of the senior management team visited the service on a monthly basis to review the quality and safety of care and treatment. Matters considered included staffing, dependency of people using the service, recruitment, end of life care, meetings, training and staff support. Following the visit, actions were set where improvements were identified and this was reviewed the following month. We found that these visits had failed to highlight or address a number of the concerns we found at the service.

An independent review had taken place of the service in February 2018 following the CQC inspection model. They had rated the service as inadequate in certain aspects. Many of the issues raised were still evident on this inspection such as those in regards to medicines management, risk assessments, care planning, information presentation, complaints, supervision and governance. They commented that 'although audits are undertaken, the same issues keep coming up'. This demonstrated that the registered provider had failed to address or respond to issues in a timely manner.

The pharmacy supplier had undertaken a review on the 6 March 2018 and highlighted the concerns we found on inspection. Subsequent medication audits by the registered provider failed to highlight and address these concerns. We brought this to the attention of the management team who informed us they were not aware of the audit and its findings.

Daily records were not reviewed as part of any review but often contained entries about care and treatment that required follow up. For example it was recorded that: wounds had not been photographed as the camera could not be found but there was no follow up as to why the staff had not reported this. There were multiple entries stating that dressings were not available for wound care but there was not followed up or investigated.

Care plan audits had not picked up the inaccurate information contained within care plans or care records to ensure that they were correctly completed. This included care plans being out of date, the lack of accurate wound records, and the failure to systematically record and review aspects of people's care including food and fluid intake and repositioning. We also found that some assessment tools were not accurate. For example: a Waterlow chart for one person stated that they had healthy skin, this was despite other records which indicated otherwise.

Accidents and incidents were reviewed on an individual basis so that changes could be made to a person's care if required. However, there was no overall analysis of these across each unit or the home to look at overall themes and trends. This meant that there was a lack of oversight as to whether adjustments to the premises, equipment, staffing or practices could affect care and treatment.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The service submitted a number of statutory notifications in regards to key occurrences within the service. However, during the inspection, we were made aware of an incident in which a person, following an accident, had sustained an injury requiring nursing intervention. CQC were not formally notified of this by way of a statutory notification.

This was a breach of Regulation 18 of the Care Quality Commission (Registration (Regulations 2009.

The last inspection rating was displayed within the service. However, the registered provider had failed to ensure that this was displayed at all on their website. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.

This was a breach of Regulation 20 A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the registered provider took steps to ensure that the rating was correctly displayed.

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 Treatment of disease, disorder or injury	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The registered provider failed to display the CQC rating on their website.

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 9 HSCA RA Regulations 2014 Person-centred care People did not receive care and treatment that met their needs or reflected their preferences.

The enforcement action we took:
We imposed a variation on the registered providers condition of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

The enforcement action we took:
We imposed a variation on the registered providers condition of registration.

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 The registered provider did not ensure that care and treatment was delivered in a safe way.

The enforcement action we took:
We imposed a variation on the registered providers condition of registration.

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 registered provider failed to operate effective systems to assess and monitor the safety and quality of the service.

The enforcement action we took:
We imposed a variation on the registered providers condition of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care Treatment of disease, disorder or injury	The registered provider could not assure us that there were enough staff to meet the needs of the people at the service.

The enforcement action we took:

We imposed a variation on the registered providers condition of registration.