Barchester Healthcare Homes Limited

The Wingfield

Inspection report

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Date of inspection visit:
18 March 2019
19 March 2019

Date of publication:
24 May 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service: The Wingfield is a 'care home' with nursing. It comprises of two separate sites, The Lodge and Memory Lane. There were 74 people living in the home at the time of the inspection.

People's experience of using this service:
There was evidence in care records to suggest that people did not always receive consistent personalised care that was responsive to their needs. Some care records showed where recommendations and methods of support were being followed accurately, others did not. This meant some people may not have received appropriate support. The management team were made aware of this shortfall at the time of the inspection and took immediate action to rectify it.

The service had improved from requires improvement to good, in the domains of safe and well led and received a good rating overall.

The registered manager had made steady progress with improvements to safety and the overall running of the service. They had a continued action plan to make further ongoing improvements.

The service had safe recruitment processes in place and staffing levels were improving, but relatives still had some concerns about the use of agency staff. However new staff were being recruited.

People told us they felt safe and staff were trained and knowledgeable about safeguarding people from the risk of abuse.

People's needs were assessed by a multi-disciplinary team and care plans were reviewed and updated regularly.

People received kind, dignified and respectful care and support from a team of committed staff. People and relatives were complimentary about the quality of care and told us they were happy with the support they received.

The service was well-led by a dedicated management team who provided good support for staff to be able to do their job effectively.
Rating at last inspection: Requires improvement (report published 14 March 2018).

Why we inspected: This was a planned inspection base on the rating at the last inspection.

Follow up: We will monitor all intelligence received about the service to inform when the next inspection should take place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe. Details are in our Safe findings below.	**Good**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was well-led Details are in our Well-Led findings below.	**Good**

The Wingfield

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of two inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
The Wingfield is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection took place on 18 and 19 March 2019 and was unannounced on the first day.

What we did:
Before the inspection we reviewed the information we held about the service and the service provider. The registered manager completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law.

During the inspection we spoke with 11 people to gather views about the care they received. We spoke with 16 relatives. We looked at records, which included 11 people's care and medicine records. We looked at a range of records about how the service was managed. We spoke with the registered manager, the deputy

manager and the regional director. We spoke with two heads of units and ten members of staff. We received feedback from two professionals who visit the service.

Good

Is the service safe?

Our findings

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

Good: People were safe and protected from avoidable harm. Legal requirements were met.

Staffing and recruitment
• At the last inspection in January 2018, we found the provider did not have robust recruitment procedures in place. This did not ensure staff employed were of suitable character and had the necessary competence, skills and experience to carry out their duties safely and effectively. This was a breach of Regulation 19, Fit and proper person's employed. At this inspection we found the service was no longer in breach of the Regulations, in this area. Improvements had been made to recruitment processes.
• We reviewed nine recruitment records and staff had been employed safely. The necessary checks and interview records were in place including full employment histories, references and enhanced DBS. The disclosure and barring service (DBS) check, allows employers to make safer recruitment decisions and helps to prevent unsuitable people from working with vulnerable groups of people.
• There were sufficient numbers of staff deployed according to the providers dependency tool. One staff member told us, "staffing is improving, staff come and go but there is always recruitment going on." Another said, "The staffing level is okay, but we have the occasional shortfall due to sickness; but we always call other people in."
• Staffing was reviewed daily at the 'heads of department stand up meeting' to account for sickness cover and to update seniors on recruitment.
• The dependency tool was reviewed regularly according to changes in people's needs and admissions. Agency staff were currently employed whilst the registered manager recruited permanent staff.
• The registered manager was interviewing three new support workers at the time of our inspection but did not recruit them, as they were not suitable for the role. They told us they only wanted competent, motivated staff who genuinely wanted to work in care.
• Some people and relatives we spoke with remained concerned about the use of agency staff and staffing levels generally. Comments included, "They have to bring in agency staff. I have noticed a slight improvement recently, there is a core of agency staff who are familiar", "I think they are short staffed", "Enough staff? Probably not although I have noticed an improvement recently."
• The managers told us there were enough staff to meet people's needs and confirmed the rostered staffing levels. The Wingfield also had a hostess role who provided refreshments and social contact throughout the day and liaised with visitors.
• We observed sufficient staff on duty at the time of our inspection. Walking around, the home was calm and people and staff appeared unrushed.

Systems and processes to safeguard people from the risk of abuse
• People and their relatives told us they felt safe. Comments included, "I've never had any concerns about [person's] safety", "I feel safe because the staff look after me and they are kind" and "They check regularly at night, it makes me feel safe."
• Staff we spoke with had the knowledge and confidence to identify safeguarding concerns and act on them

to protect people.
• Staff had received up to date safeguarding training which we confirmed from training records.
• The registered manager had contacted the local authority safeguarding team appropriately and had sent CQC required notifications.
Assessing risk, safety monitoring and management
• People's care plans contained regularly reviewed risk assessments relating to the development of pressure ulcers, moving and handling, falls, nutrition, hydration, and choking.
• Risk assessments contained guidance for staff to minimise the risks identified. These included specific recommendations from specialists such as tissue viability nurses and speech and language therapists.
• Emergency evacuation equipment was available in all stairwells and fire procedure posters were displayed. Fire safety logs were kept in each building, fire safety maintenance checks such as alarms and fire doors were completed regularly along with an annual fire risk assessment.
• Staff had regular training in fire evacuation procedures and there were grab bags at the entrance of each building containing people's individual emergency evacuation plans.

Using medicines safely
• Medicines were administered, stored and managed safely. Registered nurses were responsible for the administering of medicines and were trained by the provider and the pharmacist.
• People had their own medicine cabinets in their rooms at The Lodge which meant the temperature could not be accurately and consistently controlled. This can sometimes affect the efficacy of the medicine. The deputy manager told us this system was being changed and people's medicines would be stored in a medicines trolley in the medicines room. Temperature checks we saw were within acceptable limits.
• At Memory Lane people had their own container on the medicines trolley.
• We observed a medicines administration round at both The Lodge and Memory Lane. The nurse demonstrated an awareness of the needs and preferences of the people they administered medicines to and their practice was safe.
• Medicines administration records (MAR) were completed accurately. Two MAR's did not have a photograph of the person attached, a note stated a photograph had been taken on 8 March but had not been printed. When this was brought to the attention of the deputy manager, it was actioned immediately.
• There were protocols in place for 'as required' medicines we reviewed apart from one person who had two 'as required' medicines. When this was brought to the attention of the deputy manager, it was actioned immediately.
• Homely remedies (such as cough linctus) protocols were in place and had been signed by the GP. Transdermal patches had been administered accurately in rotation and recorded on a body map for accuracy. Topical prescribed creams had been recorded with gaps in only one chart reviewed.

Preventing and controlling infection
• The Lodge and Memory Lane were clean, tidy and free from bad odours. We observed housekeeping staff cleaning rooms, communal areas and bathrooms. The head of housekeeping told us there were cleaning schedules in place and the 'resident of the day' had their room deep cleaned monthly.
• We saw staff using personal protective equipment such as aprons and gloves and there were sufficient paper towels and hand gels in bathrooms.
• At the last inspection it was noted that some of the wooden toilet seats and floors were cracked. At this inspection we found these had been replaced.

Learning lessons when things go wrong
• Accidents and incidents were recorded and analysed by the general manager. Findings were discussed at the daily 'stand up meetings' and changes made to care plans or systems actioned such as regular monitoring.

• Accidents and incidents were reviewed centrally by senior managers and actions signed off as completed before closing.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed prior to moving to The Wingfield. Assessments included people's life histories, family details, likes, dislikes and preferences. Some people with dementia had a 'this is me' document to assist staff in getting to know the person. Assessment details informed people's care plans.
• There were multi-disciplinary assessments in place from specialists such as occupational therapists, physiotherapists and specialist mental health nurses.
• Relatives were positive about staff knowledge of their family members. Some comments were, "I'm confident that the staff understand and look after [person's] needs", "We were involved in the assessment and they know [my relative's] needs well." However, some relatives felt agency staff did not know their relative as well as permanent staff. One stated, "When agency staff are on duty we'll find [person] isn't wearing their glasses, for example."

Staff support: induction, training, skills and experience
● People and relatives we spoke with told us the staff were all "well trained, capable and competent" to look after them or their relatives. One relative told us, "The staff have good skills to cope with complex and difficult behaviour."
• Staff told us they had good training and had completed refreshers of all mandatory areas. They told us they felt skilled to carry out their roles.
• We saw a comprehensive training matrix which included face to face and e-learning. Training included, safeguarding, infection control, manual handling and person-centred care.
• Staff had a thorough induction and shadowed more experienced staff until they were assessed as being competent to work independently. Staff had regular one to one supervision with their line manager and an annual appraisal.

Supporting people to eat and drink enough to maintain a balanced diet
●We observed the mealtime service at both Memory Lane and The Lodge. Staff sat with people to assist them. They made eye contact and conversation during the support. People appeared to enjoy their meal which was unrushed.
• Tables were attractively presented and laid with napkins and condiments. However, there were no menus on the tables, just one large menu displayed on the wall.
• There were jugs of water, squash and snacks available in communal areas which we saw people helping themselves to.
• Food and fluid charts were fully completed. People were weighed monthly and if found to be losing weight were given additional calories in the form of fortified meals, supplements where prescribed or snacks and referred to the dietician.

• We observed the hostess assisting a person to drink during the tea round. We saw staff regularly checking if people wanted drinks.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People's care plans contained specific guidelines for staff to follow in relation to individual's health needs. For example, where people had been assessed by the specialist tissue viability nurse, we saw guidance was being followed and monitored regularly.
• Where people required protection for their skin from pressure, we saw air mattresses with charts confirming the level was set correctly. Re-positioning and weight charts were in place to ensure they were supported to change position regularly at the person's current body weight.
• People were supported to see the visiting GP when required and attend appointments at hospital or clinics outside of the home.

Adapting service, design, decoration to meet people's needs
●Areas in both parts of the home had been refurbished which looked pleasant and homely.
• Memory Lane was sparse in terms of things of interest - things to look at, touch or do; which is particularly important for people living with dementia. The registered manager told us they planned to re-furbish the sensory room and make it part of the activities programme for people.
• They also planned to introduce areas of interest in Memory Lane to support people's memory and daily experience. These included an indoor garden, a laundry with a folding area and washing line.
• The lift had been unavoidably out of order in The Lodge for several days due to needing a new part. Although this meant people could not access the downstairs lounge, temporary provision was made. There were smaller communal lounge areas in the upstairs levels and large screen TV's were brought in and an increase in one to one time with activities staff.
• Both areas of the home had accessible outside spaces, gardens and seating areas which were used throughout the year.

Ensuring consent to care and treatment in line with law and guidance
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 take 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● People's care plans contained consent forms and we observed staff asking permission and consent prior to supporting people.
• Where appropriate, mental capacity assessments had been completed along with their corresponding best interests' decisions.
• Legal authorities were in place, for example Lasting Power of Attorney for Health and Welfare and Finance and Property. There were copies of the registrations in people's files. This meant people had the correct representation in place to help them with consent and decision making.

• The provider had made appropriate applications to the local authority for DoLS.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity
● People told us they were treated with kindness. There were many positive comments made about staff including, "Staff listen, and I feel valued. The [staff] here are very caring, all of them", "They are all very good on the whole. They are very kind, I'm very glad I came here" and "There is always someone to give you a hug, it's so important. There is always someone to acknowledge I'm here."
• The relatives were equally positive. One relative told us, "The staff are very kind, they always speak to [family member] in a respectful way. Another said, "They sometimes sing to [person] to calm them down".
• We observed staff interacting with people in a friendly and respectful way. Staff responded to requests for support calmly and we observed call bells being answered promptly.
• We saw people's rooms were individualised with personal items such as pictures and photographs.
• Staff we spoke with were passionate about the care they provided and knew individuals well, including their families, backgrounds and routines.

Supporting people to express their views and be involved in making decisions about their care
• People were supported to be as independent as possible within their individual abilities.
• We observed people being offered choices to enable them to make their own decisions about what to do, where to sit and how much support they wanted. For example, staff offered assistance to cut up food and then encouraged people to eat independently.
• One person told us they were asked on their first day, if they minded having a male carer. "I said, no I don't mind. The personal care is good. I'm happy here they are all very pleasant."
• People were supported to maintain close relationships and we observed many visitors throughout the day. Relatives told us there were no restrictions on when they could visit and they felt welcome. One relative told us, "They have built up a good relationship with us. The key worker keeps me informed and will always approach and tell me if something has happened."

Respecting and promoting people's privacy, dignity and independence
• People's confidential records were kept securely. We saw care plans and daily records were written with respectful language and acknowledged people's abilities.
• People were spoken to in a gentle and calm manner and we observed many kind and compassionate interactions.
• We observed staff knocking on doors, requesting permission to assist people and ensuring people were not rushed. For example, during the lunchtime meal service, staff asked and made sure people had finished their meal before removing their plate. Staff were heard saying, "Don't rush [name], there's plenty of time."
• People looked well cared for with clean clothes, hair and fingernails. Spectacles and hearing aids were being worn.

• Staff spoke passionately about the respectful care they provided. One nurse told us, " I am positive for The Wingfield and I want the best for my work and the residents. We are here because of the residents, we teach everyone to respect that it is their home, we have to respect when we visit them, respect their wishes and know them well, to help them. If we don't know the residents, we won't know how to look after them."

Requires Improvement

Is the service responsive?

Our findings

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

RI: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Care plans were based on assessments and related to, amongst others, communication, mobility and falls, tissue viability, cultural, spiritual and social values, and hopes and concerns for the future. Care plans had been reviewed monthly by a registered nurse. Evidence of annual care plan reviews involving the person and their advocate were seen.
• Where people had specific care needs, such as catheter care or wound care, then care plans were in place relating to those needs. Records of catheter changes and wound dressings were kept. One person had a care plan in place about the management of their specific neurological condition.
• However, there was mixed evidence to suggest that people received personalised care that was responsive to their needs. For example, one person had been admitted to the home with a pressure ulcer. Following assessment, appropriate pressure relief equipment was provided and was being used. The person was having their position changed at the required frequency and their wound was being regularly dressed. The person confirmed that they had been involved in the care planning process and that they were happy with the support they received.
• Conversely, the care plan for another person admitted to the home with a pressure ulcer did not reflect current practice regarding repositioning. The care plan stated that the person required repositioning every two hours during the day and every three hours during the night. Records for the 16th, 17th and 18th March 2019 indicated that the person was being repositioned every four hours and that on three occasions had remained in the same position for between five and six hours. It was noted that they had declined to be repositioned on one occasion during two of these periods. It was also noted that an entry had been made in the daily progress and evaluation notes for the 17th, which read 'two hourly repositioning by slide sheet.' This did not reflect the recording on the repositioning record for that day.
• One of their pressure sores was improving, whilst the other had deteriorated from a category two to a category four. The person's care plans did not fully reflect their wishes in relation to repositioning and there were no statements relating to their capacity to make these decisions. The care plan also lacked specific details regarding the settings of air mattress being used.
• It was also noted that retrospective entries had been made on the person's repositioning and fluid intake chart on the first day of the inspection. These findings were brought to the registered mangers attention and the care plan was rewritten following consultation with the person.
• This meant that people were not receiving consistent care that met their individual needs.
• Activities held in The Lodge over the two days of the visit included a musician, a music therapist and a visit by a therapy dog. A 'friendship group' meeting was held every month in The Lodge, which enabled those living there to meet and mix with people from the local community. The deputy manager reported that two of the people had subsequently become volunteers in the home.
• The manager stated that activity staff were employed and worked from 11.00am to 7.00pm each day. There was currently an activity coordinator supported by a part time assistant. The registered manager was

currently recruiting a further activity assistant.

Improving care quality in response to complaints or concerns

● The home offers the opportunity for people, relatives and staff to feedback or raise concerns. Regular meetings were held where views could be aired and the registered manager had an 'open door' policy to encourage feedback and discussion.

• The provider had a complaints policy and procedure in place which meant concerns raised were acted upon immediately and reviewed by the management team before being signed off as completed satisfactorily.

• There were no current complaints being processed at the time of our inspection.

End of life care and support

• No-one was receiving end of life care at the time of our inspection. However, some people had been prescribed anticipatory medicines should their condition should deteriorate.

• Care Plans contained treatment and escalation plans which had been reviewed by the visiting GP and some contained an 'Advance Care Plan'. These detailed people's wishes regarding resuscitation and whether they wished to remain in the home or receive hospital treatment if they became acutely ill.

Good

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

Good: The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

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

● The Wingfield had a new registered manager in post who had made steady changes and improvements to the running of the home. We received good feedback from people, relatives and staff about the new registered manager and deputy manager and the positive difference they were making to the home. Comments included, "[the registered manager] is positive and proactive, [she] comes to us every morning to see how the residents are and staffing. Always walks around, I feel supported by them", "The manager is good now, we are like a family and we are committed to making this place work" and "The management are very good; both are approachable and know what is happening."
• There was a daily stand up meeting with all heads of departments to discuss events and updates of the day. This included home maintenance, housekeeping, staffing, activities and any significant clinical changes to people's needs. This meant communication between departments was good which was cascaded throughout the staff team.
• The registered manager had a schedule of audits covering area such as accidents and incidents, medicines, housekeeping, training and supervision of staff. There was regular monitoring, reviewing and evaluating of quality assurance findings by several layers of management. Action plans were put in place with a timescale of achievement and sign off as completed.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
● The provider had a clear vision and values for the service. The registered manager told us they encouraged the staff team to live by the values of amongst others, respect, integrity and responsibility to 'provide excellent care for our residents'. These values were evident when we spoke with staff who were proud to deliver good quality care to the people they supported.
• Staff and relatives we spoke with told us they thought the service had improved and the new management team was making an impact on standards.
• The management team had a good understanding of their responsibilities under the duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• The Wingfield had a community engagement team who created events for the local community to bring people together. A friendship group enabled people from the community to come into The Wingfield for a social lunch.

• The home worked closely with the local authority adult social care teams and the clinical commissioning group. People who were not well enough to return home from hospital were admitted to The Wingfield where they received support from occupational and physiotherapists to prepare them to return home.