The Abbeyfield (Maidenhead) Society Limited

Winton House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Winton House is a residential care home providing personal care up to 36 people aged 65 and over. At the time of the inspection 21 older people with physical frailty were living at the home. Each person had an individual room with en-suite facilities. People had access to a dedicated dining room and lounge. Around the home there were many different seating options for people to choose. The home had its own hair dressing room, which we observed was popular on the day of inspection.

People's experience of using this service and what we found
People were not routinely and consistently protected from avoidable harm. We found improvement were required in the management of risks posed to people. For instance, people who had fallen previously did not always have a risk assessment in place to advise staff on how they should be supported to prevent a reoccurrence. Risks associated with the environment were not routinely managed to reduce harm to people. Improvements were required in water safety management.

When accidents or incidents occurred, these were not routinely investigated to understand how to minimise a repeat event.

People were not routinely supported with their prescribed medicines by staff who followed best practice guidance or who had been assessed as competent to administer medicines. We found the registered manager had delegated competency assessments to other staff and had no process in place to check if they had been completed. Records relating to people's medicines were not always accurate.

People were supported by a service that was not well-led. There was a lack of managerial oversight from the provider and registered manager. Systems were either not in place or ineffective to drive improvements in the service.

We found a number of breaches of the regulations.The provider and registered manager lacked knowledge on how to comply with the regulations The provider and registered manager failed to ensure they reported important events to us when required.The provider's policy and procedures did not always reference or follow best practice. Internal audits carried out did not pick up the issues we found.

We have made a recommendation about the provider's management of potential abuse. People were supported by staff who had received training on how to recognise abuse. However, the providers policy and procedures did not reference best practice guidance.

We have made a recommendation about ensuring staff are recruited safely. We found references for new staff were not always verified or came from a professional address.

We found mixed evidence on how well the service had managed through the Covid-19 pandemic. We have signposted the provider to resources to develop their approach with regards to following government

guidance on use of PPE and social distancing for staff. However, people told us, "It's a nice place. It's clean and well maintained", "It's clean and modern", "It's a nice environment. The staff know her well and she's well looked after".

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. Documentation did not consistently follow the principles of the mental capacity act code of practice.

People told us they felt staff looked after them and they were kind and caring. Comments from people included, "The carers are very good and kind", "I definitely feel safe living here" and "They [staff] treat you and approach you the right way".

People were supported to keep in contact with family and friends. Comments included, "When we had her new great grandson, we used Zoom to speak to her. A member of staff was very good and sat with her", "My daughter came into the home to see me yesterday for the first time since Covid-19 started. I didn't want her to come in, I'm happy with Skype but she brought my great grandchild and we had great fun".

Relatives told us they were happy with the support their family member received. Relatives told us "There's always someone there. We can sleep at night now." And "It's a nice environment. The staff know her well and she's well looked after." Another relative told us "It has taken such a weight off my shoulders to know she is safe and happy here".

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 23 August 2018).

Why we inspected
The inspection was prompted in part due to concerns about the effectiveness of the provider's risk management systems and good governance. A decision was made for us to undertake a focused inspection to examine those risks and review the key questions of safe and well-led only.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.
The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.
You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Winton House 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 risk management and good governance.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Winton House

Detailed findings

Background to this inspection

The inspection
We carried out this focused inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors 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
Winton house 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 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
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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. We used all of this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service and 12 relatives about their experience of the care provided. We spoke with five staff members, including the nominated individual who is responsible for supervising the management of the service on behalf of the provider. We spoke with the registered manager, head of maintenance, a senior care worker responsible for medicine management and the lead member of staff for activities. We received feedback from three care workers.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were requested and reviewed, including health and safety records, policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● People were not routinely and effectively protected from avoidable harm. We found the provider had not ensured they had done all that was reasonably practicable to mitigate risks. Risk assessments had not always been completed when required. The deputy manager had identified this and was working through people's care plans to update guidance for staff on how to mitigate potential risk of harm to people. The registered manager and provider had not identified the omissions of risk assessments in their managerial oversight of the home.

● The provider's "Prevention and Management of Falls Policy" dated December 2020, stated "The care plan and falls risk management must be reviewed whenever there is a significant change indicated in the resident's condition or after an adverse event such as a fall." We found this was not followed. One person's care record showed they had experienced 11 falls in 2020, some of which resulted in the person being treated in hospital. Records showed the registered manager had only completed a falls risk assessment on 17 December 2020 stating the person had 'repetitive falls.' Another person had experienced three falls in 2020 and no risk assessment was in place.

● Falls risk assessments did not routinely provide adequate advice or guidance to staff on how to prevent the person falling or harm to them. One person had a medical condition which could cause them to fall. Their mobility and falls care plan failed to mention the condition and how it impacted the person. Their falls risk assessment mentioned the condition but gave no guidance to staff on how to manage this, the person was advised to pull the call bell if they felt they were unsteady. This placed the person at risk of potential harm.

● People who had medical conditions and were prescribed medicines which had the potential to cause harm were not protected. We found risk assessments were either not in place or effective for people who were administered anticoagulant medicine. This medicine had the potential to cause internal and external bleeding.

● People were exposed to a potentially dangerous environment. We found the provider and registered manager failed to ensure the building's water supply was safe. Routine checks and maintenance to prevent the growth of Legionella were not always completed. We found a Legionella risk assessment had been completed in May 2021. This identified there was no previous risk assessment in place and highlighted 15 areas of immediate attention required to improve water safety. We spoke with the registered manager who confirmed the person in charge of maintenance had not received any Legionella awareness training. However, they themselves had received awareness training on the prevention of Legionella.

● We found the registered manager and provider lacked understanding about health and safety. The provider's "Health and Safety Checks" policy dated December 2020 did not reflect best practice and legal requirements stated by The Health and Safety Executive (HSE). For instance, the check list did not refer to

routine water checks required or the checking of window restrictors for rooms above the ground floor. We found no records had been completed for checks on water temperature in 2021. This was confirmed by the registered manager who stated, "I do not have any for 2021 to send as evidence."
● Health and safety audits completed in the home did not identify the shortfalls we found. The latest "Health and Safety Checklist" fully completed on 14 June 2021 stated "Water temperatures routinely checked to prevent Legionella" had been completed. We found this was not routinely and consistently the case.
● People were not routinely prevented from the risk of scalding. We found no checks on water temperature were made prior to people using showers. This was confirmed by the registered manager who told us "I cannot provide evidence of water temperatures taken prior to showers.
With this now in mind, we will move forward and implement this by creating a temperature checklist for the showers."

People were placed at potential risk of harm due to the poor management of risks. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were protected from the risk of fire. A fire risk assessment dated 25 February 2021. Regular checks on fire equipment were carried out. We found equipment used by staff was routinely checked to ensure it was safe to use.
● People told us when they had fallen staff had been responsive. Comments included, "I shouted for help yesterday and at least four people came and the Management came too" and "I definitely feel safe living here. I have had a fall or two but they (staff) have strong arms and they come to pick me up. I cut my scalp once but amazingly I was found very quickly, there are so many people to help me, they ran, they were close by".

Using medicines safely

At the last inspection we made a recommendation about how the provider responded to medicine errors. At this inspection we found system in place did not routinely identify errors in a timely manner. Audits completed by staff did not always pick up errors made. We found further improvements were required in medicine management.

● People were not routinely and consistently supported by staff who had their competency to administer medicine checked. We found the registered manager had not carried out robust assessments on staff to ensure they had the right skills and training received was understood. A senior member of staff had been delegated the task of medicine management and routine checks on staff. However, they had not received a competency assessment by the registered manager. We discussed this with the registered manager who told us they would ensure all staff were equipped with the right skills and knowledge to support people with their medicines.
● The providers medicine policy, "Drug administration Procedure/Policy" dated December 2020 did not make reference to best practice stated in The National Institute for Health and Care Excellence (NICE) guidance. We provided this feedback to the nominated individual and registered manager. The nominated individual told us "We are currently reviewing this policy and procedure."
● We found records relating the people's medicine management were not routinely and consistently accurate or reflected best practice. For instance, where medicine administration records (MARs) were hand-written, they had not always been signed by two staff to ensure the information was accurate. We found one medicine which needed additional record management due to the potential for abuse, did not comply with

the required legislation (The Misuse of Drugs Regulations 2001).

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate medicines was effectively managed. 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.

● We observed staff who supported people with their medicine, completed this in a professional and caring manner. People told us they were happy with the support they received regarding their medicines. Comments included, "I don't take much medication but it is all handled properly, I don't have any problems there" and "I take a lot of medication, I take Warfarin but that is all dealt with without a problem. I take six tablets in the morning and six more at night. I know all my medication by name, and I feel confident".

Learning lessons when things go wrong
● People were not supported by a service that routinely and consistently responded to accident and incidents in a way that learnt lessons when things went wrong.
● People who had fallen or had suffered injuries were not protected from a future re-occurrence. The provider's policies and procedures were not robust enough to ensure all accidents, near misses were recorded and or investigated.
● One person's care record showed they had been admitted to hospital after collapsing and being supported to the ground by staff on 24 May 2021 but there were no completed accident or incident forms. There were no documents to show this had been thoroughly investigated, monitored to make sure appropriate action was taken to prevent further occurrences; and shared to promote learning.

The provider did not maintain complete and contemporaneous records in relation to people's care and decisions taken in relation to the support provided. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were supported by staff who had received training on how to protect them from potential abuse. However, the policies and procedures in place did not follow best practice or current legislation. The "safeguarding Adult Policy" dated December 2020, failed to reference The Care Act 2014 and list possible categories of abuse. The policy also referenced another local authority multi-agency procedure, rather than the procedures for the local authority where the home was situated. We bought this to the attention of the nominated individual, who advised they were aware of this. To date no change has been made to the policy.
● The registered manager had not always followed the provider's policy. The provider expected a safeguarding log to be completed in the event of alleged abuse. We found this had not been completed. The registered manager confirmed this, I would like to be clear that I have not filled out a recorded safeguarding log. Moving forward from now on I will be doing this."

We recommend the provider seek support from a reputable source to improve policy and procedures for safeguarding people from abuse.

● People told us they felt safe living in the home. Comments included, "I am and feel absolutely safe here" and I am safe here. I seem to know what they (staff) are talking about even if I can't always hear them". A relative told us, "It has taken such a weight off my shoulders to know she is safe and happy here" and "My mother had a fall and a big hip operation after she fell in her own home. I feel that she is safe in here". They went onto tell us "She came here at first as respite, for just one week but she was so well looked after. She

went back to her home after the one week but then she asked her family to let her come back to live in Winton House".

Staffing and recruitment
● Recruitment practices were not always safe. We looked at staff records for three staff members who had been recruited within the last 12 months.
● The provider did not always obtain references from potential new recruit's current or last employers. The registered manager accepted references without verifying the references were authentic. For instance, one member of staff professional reference was sent from a private email address.
● We provided feedback to the registered manager and nominated individual and sought clarification from them after the inspection.

We recommend the provider seeks guidance from a reputable source on safe recruitment of staff.

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 promoting safety through the layout and hygiene practices of the premises.

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

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

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

People and their relatives told us "It's a nice place. It's clean and well maintained", "It's clean and modern", "It's a nice environment. The staff know her well and she's well looked after". People gave us positive feedback about how staff had managed through the Covid-19 pandemic. One person told us "I think they have handled it well here, but I think it has been more stressful for everyone". Another person commented, "I have calls from an old friend from my Church, she keeps in touch and she wants to come in to see me. People can come into the sun-room and take all the precautions; she's booked now to come and see me in my room which I want and which I will enjoy".

We have signposted the provider to resources to develop their approach with regards to following government guidance on use of PPE and social distancing for staff.

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.

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

- The registered manager and provider failed to ensure they routinely complied with all the regulatory requirements. Providers and registered managers are required to notify us of certain incidents or events which have occurred during, or as a result of, the provision of care and support to people. One notifiable event is when there has been an allegation of abuse. We found we had not routinely and consistently been made aware of events which had been reported to the local authority as alleged abuse. The provider had made two abuse notifications to us since 2017. However, we found at least four further incidents which had been reported to the local authority which had not been reported to us.
- We found people had fallen and had sustained a serious injury. We had not been notified of this. We had to remind the registered manager and provider of the requirements on them to report certain events to us.

The provider had failed to notify us of all the events it was legally required to do so. This was a beach of Regulation 18 (Notification of other incidents) of The Care Quality Commission (Registration) Regulations 2009

- The provider and registered manager failed to ensure there was effective managerial oversight of the home. The registered manager was the health and safety representative for the provider. They had delegated a number of tasks to other staff. However, they did not have any systems in place to ensure tasks delegated had been completed. We found the registered manager was not aware of many of the issues we identified especially regarding the health and safety of the building.
- Audits carried out by the registered manager and nominated individual were not effective and did not pick up the issues we found which included gaps in risk assessments, medicine management and staff recruitment records. Therefore, they had not routinely addressed risks that could cause significant harm to people. It is the responsibility of the registered provider to operate systems that prevent the breaches of regulation and mitigate risk relating to health and safety. We found this was not routinely completed.
- The "Health and Safety Checklist" which the provider expected to be completed every three months, did not reference current legislation. For instance, it referred to the Health and Social Care Act 2008 (Regulated Activities) 2010 and not the updated version in 2014.

The provider failed to evaluate and improve their practice in respect of the monitoring they had completed to drive forward improvements. People were put at potential risk of harm as effective governance arrangements were not in place. This was a breach of Regulation 17 (Good Governance) of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was a registered manager in post.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were not routinely supported by a service that was well managed. The provider's policies and procedures were not robust and failed to provide good guidance for staff based on best practice or legislation. For instance, the provider medicine policy dated December 2020 failed to reference NICE guidance.

● The provider's Prevention and Management of Falls policy dated December 2020, stated where people experienced falls which resulted either no injuries or minor injuries, a 'post falls assessment' would need to be completed. Care records showed this was not consistently followed.

● Care plans failed to document people's protected characteristics such as their gender, race and sexuality as outlined under the Equality Act 2010. This meant the service could not be assured staffs' working practices would prevent discrimination and protect people's their human rights.

● The service did seek feedback from people, their relatives, however, the registered manager was unable to demonstrate what action they had carried out as a result of the feedback.

The provider failed to evaluate and improve their practice in respect of the monitoring they had completed to drive forward improvements. People were put at potential risk of harm as effective governance arrangements were not in place. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● People and their relatives told us they were supported to keep in contact with each other. One person told us "I didn't know what Zoom was this time last year but I use it now. There is an email link from the home to relatives, the assistant manager organises it". Another person told us "My niece visits me regularly now, things are beginning to get back to normal, I think they [staff] have handled it all very well, they all stick to the rules as far as I'm concerned".

● The service worked with external healthcare professional to help them manage people's needs. Two healthcare professionals told us although staff demonstrated kindness towards people. On occasions they felt staff were reactive rather than proactive in meeting people's needs. One healthcare professional told us staff were not always able to demonstrate up to date information to them as records had not been updated.

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

● Providers are required to comply with the duty of candour (DOC) statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity.

● We found the registered provider had a policy in place which followed the guidance within the regulation. We found the registered manager did not routinely record actions taken as a result of concerns raised about care provided. We found people had experienced serious injuries, such as a fractured bone. This should

have triggered the duty of candour requirements. We asked to see evidence of how the registered manager had met the regulation. No records were shared with us. We found we needed to discuss the duty of candour requirements with the senior management team to help them understand their legal requirements.

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

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not being met. The provider and registered manager did not report all the required events to us when needed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour How the regulation was not being met. The registered manager failed to ensure they triggered the duty of candour requirements when needed.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met. The provider and registered failed to ensure people were protected from avoidable harm. Risk assessment were either not in place or not effective in mitigating potential harm. People were not always supported with the prescribed medicines by staff who had been assessed as competent. Records relating to medicines did not always follow best practice guidance.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met. The provider and registered manager failed to ensure effective systems were in place to manage people's needs. The provider's policy and procedures did not reference or follow government guidance or legislation.

The enforcement action we took:

We issued a warning notice.