Barchester Healthcare Homes Limited

Werrington Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Werrington Lodge 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.

Werrington Lodge accommodates 82 people in one purpose built building. At the time of the inspection there were 61 older people living in the home.

The inspection took place on 25 and 27 April 2018 and was unannounced. At the previous inspection in September 2017 the home was rated as good overall. At this inspection we found it had deteriorated to requires improvement.

At the time of the inspection there was a registered manager in place. 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.

People's health was placed at risk because they were not always receiving their medicines as prescribed. The medication administration records had not always been completed accurately. Staff had not always followed instructions for how some medicines should be administered such as half an hour before food. Medicines were stored securely.

Although risk assessments had been completed staff were not always aware of or had not followed the guidance. This placed people at risk to their health and safety. Staff were aware of safeguarding procedures and what action they should take if they suspected anyone was at risk of harm. Incidents and accidents were analysed so that action could be taken to prevent a reoccurrence.

Staffing levels were sufficient to meet people's basic needs but this was not always done in a timely manner. The home was using a tool to analyse how many staffing hours were required. The registered manager was trying to recruit to a new twilight shift to ensure people's needs were met in a more timely way. Safe recruitment practices were followed to ensure staff were suitable to work in a care home. Staff received the training and support they required.

People were provided with a choice of food and drink that they enjoyed. When needed, people received the support they needed from staff to eat and drink. The monitoring of food and drink intake for people at risk of malnutrition or dehydration was not always completed accurately.

People were supported by kind and caring staff. Staff noticed when people became anxious and gave them the reassurance they needed. People's privacy and dignity were upheld. People and their relatives had been asked their views on the quality of the service and what improvements

could be made so that they were involved in the running of the home. Visitors were made to feel welcome to the home. People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

Care plans did not always provide staff with the information that they required to meet people's individual care and support needs. This meant that they were at risk of not having their needs met in a person-centred way.

The systems being used to assess, monitor and improve the service provided were not always effective. This was because not all areas requiring improvement had been identified.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

People had not always received their medicines as prescribed. This put their health at risk.

Staff did not always follow the guidance in people's risk assessments. This placed people at unnecessary risk to their health and safety.

There was a thorough staff recruitment procedure to ensure the right people were employed.

Is the service effective?

Good

The service was effective.

People were provided with a choice of food and drink. However, when needed this was not always monitored accurately.

Staff received training and supervisions to ensure they had the knowledge they required to carry out their role.

People had access to a range of healthcare services to support them with maintaining their health and wellbeing.

Is the service caring?

Good

The service was caring.

Members of staff were kind and caring.

People's dignity and privacy was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care and support needs were not always planned for or accurately evaluated to reflect any changes that were needed.

People were encouraged and enabled to take part in activities and events that they enjoyed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The systems for assessing, monitoring, and identifying areas for improvement were not always effective.

Notifications were submitted to the Care Quality Commission as required by the law.

People and staff were involved in, and able to make comments in relation to the running of the service.

Werrington Lodge

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 was planned to check 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 on 25 and 27 April 2018 and was unannounced. The inspection was carried out by three inspectors and a pharmacist inspector.

We reviewed notifications received by the Care Quality Commission (CQC) and other information we hold about the service. A notification is information about important events which the service is required to send us by law. We also looked at information we held about the service.

We spoke with four people who use the service and two relatives. We observed how staff interacted with people who lived at the home. We used observation as a way of viewing the care and support provided by staff. This was used to help us understand the experience of people who were present on the day of the inspection, but could not talk to us. We spoke with the registered manager, divisional director, regional director, a registered manager from another care home owned by the same provider, three nurses, a senior care assistant, a care assistant and a housekeeping assistant.

We looked at records including medication administration records, staff recruitment and supervisions. We also looked at records at records in relation to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in September 2017 the service had deteriorated to Requires Improvement. This was because safeguarding procedures had not always been followed. This had improved although one incident had not been reported in a timely manner to the relevant agencies.

At this inspection we found that people had a photograph to identify them as part of their medicines record. Allergies were documented. People who were receiving their medicines covertly had been assessed appropriately by a multidisciplinary team and administration of medicines covertly was decided to be in their best interests. Covert medicine administration involves hiding the medicine in food or drink.

All medicines, requiring cold storage, were available, suitable for use and securely stored. Homely remedies were available and this allowed staff to respond quickly to minor ailments such as a headache, cough or sore throat. Medicines that were required intermittently i.e. every three months were clearly marked when the next dose was due.

However, we found that people were not always receiving their medicines as prescribed. Administration of medicines was recorded on medicines administration record (MAR) charts which were provided by the pharmacy. During our inspection we looked at 21 MAR charts and found that there were 32 gaps in the records. These included medicines for epilepsy and Parkinson's disease, steroids, analgesics, antidepressants and an antipsychotic. A monitoring form which had been introduced for staff to sign after each medicine round to check that records were complete was not always being done. The homes local medicines policy stated "all MAR sheets are to be checked at the end and start of each shift by the two registered nurses. MAR sheets should be checked to ensure there are no missing signatures or missing codes. The 'Medication Administration Drug checklist' must then be completed and signed by both Registered Nurses to evidence these checks."

In addition, handwritten additions or changes to the MAR charts had not always been signed and checked by a second member of staff. Medicines that were only prescribed for a short period of time were still on the MAR chart and supplies were still being sent by the pharmacy which resulted in items being wasted. The ordering system did not seem effective as each month medicines were being destroyed for patients who were still resident in the home.

An antibiotic requiring administration one hour before food or two hours after food was being given at mealtimes. One medicine, which was required to be given 30 minutes before breakfast or other medicines, was being administered at the same time as other medicines. People who were receiving medicines as skin patches did not always have the site of application rotated as recommended by the manufacturer; one person did not have a monitoring chart in place at all. A person requiring warfarin, a drug used to prevent blood clots, required different doses to be given on alternate days. This was incorrectly given as the same dose two days running.

In some cases, protocols for the administration of 'as required' medicines were not available. These

protocols provide guidance to staff as to when it is appropriate to administer medicines that are not required regularly such as analgesics or laxatives.

When people need end of life care they sometimes have their medicines administered through a 24-hour syringe pump directly into the skin. This pump wasn't changed promptly and left the person without pain relief for over three and a half hours. This happened on two separate occasions.

There were records for medicines being applied topically such as creams and ointments in people's rooms. Although, medicines' administration records were not always available correctly or completed.

The service had not reported any medicine incidents within the last six months although we had found gaps in the administration records. Audits were being performed both internally and by the visiting pharmacy where these issues had not been picked up.

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

Risk assessments had been completed so that staff had the information about how they could reduce risks to people. However, we found that staff were not always aware of the information in the risk assessments. For example, we asked a senior nurse how many people required repositioning (in the area of the home they were working in) to reduce the risk of pressure ulcers forming. They told us they were unsure but that it would be listed on the handover sheet (a document used to inform staff coming on shift of any changes or issues). However, when we checked the handover sheet it did not accurately reflect the names of people that needed repositioning. This meant that there was a risk that staff would not know the information they needed to reduce risks to people.

Although when needed people had been referred to a speech and language therapist (SALT) for assessment of eating and drinking their guidance wasn't always followed in practice. For example, one person's assessment stated to use an open cup with no lid and no straw in it. The drinks were to be thickened to a stage one (syrup consistency). There was a glass of straws on the bedside table and two drinks. The person's drinking guidance was not being adhered to due to the use of lids and straws This put the person at risk of not being effectively supported with their eating and drinking as the SALT's guidance was not being followed.

Staff told us and records we saw, confirmed that staff had received training in safeguarding and protecting people from harm. One person told us, "I feel safe living here, I've never had any cause for concern. If I needed to, I would talk to one of the nurses." Staff were able to tell us the correct procedure to follow if they suspected anyone had suffered any harm, including what outside agencies they would contact with any concerns. A staff member told us, "It's important to keep people safe as they rely on us. They trust us." The records showed that any safeguarding issues were normally reported to the relevant agencies. We asked to see a incident report for a conflict between two people however this could not be found. It was thought that this was due to paperwork being archived due to decoration of the building.

The registered manager told us that they used a system based on people's assessed needs to determine the number of staff needed for each shift. The registered manager also stated that they were recruiting to a new "twilight" shift to enable more staff at peak times of activity during the day and evening. We observed that during the inspection call bells were answered promptly.

Staff completed accident and incident forms and the details were transferred to the providers computer

system and viewed on a weekly basis by the regional director. This was to assess if any extra action was needed to be taken to avoid a reoccurrence.

Records showed and staff confirmed that thorough recruitment practices were followed before new staff were appointed. Pre-employment checks included references and criminal records check. A review of the personnel records showed all checks were completed before staff commenced working in the service.

There was an infection control lead for the home. Infection control policies and procedures were in place and regular infection control audits were carried out. Staff completed infection control training and were aware of their responsibilities. Staff were seen to use personal protective equipment such as gloves appropriately on the day of the inspection.

Maintenance and safety checks such as testing of the fire alarms had been carried out on a regular basis.

Good

Is the service effective?

Our findings

There were pre- admission forms and assessments in place for staff to complete before people moved into the home. This information was used to ensure the staff could meet people's needs and as the basis of people's initial care plans. The assessments included information about peoples physical, mental health and social needs.

People had been assessed to see if they were at risk of malnutrition or dehydration. Where necessary staff were required to record what people had to eat and drink. However, we found that not all of the fluid intake records showed a clear target of how much the person was aiming for. The recording charts had not always been totalled up to show if people were meeting their targets so any necessary action could be taken. After the inspection the regional director stated that a process had been put in place to ensure that the fluid charts were checked throughout the day. This was so that action could be taken if needed.

Staff told us that they mainly received the support they needed. We saw that the majority of the staff team had received the training they required to carry out their role effectively. There was a system in place to ensure that when needed staff were booked on refresher training to ensure their skills and knowledge was up to date with best practice guidance. The records showed that 93% of staff had received a supervision and the registered manager stated that the others were scheduled to take place.

People received the support they required to ensure they had sufficient food and drink. One person told us, "I had a cup of tea at 3am, it wasn't a problem." People told us they could choose where they would like their meals. Another person told us, "I can get up for food if I want to. I do my best to get out of bed if I can. The staff do ask what I want to do today and if I want to have my dinner in the dining room." We observed staff when needed supporting people to eat. Staff sat with people and assisted them at a pace that suited the person. We saw that people were offered options at meal times however a better description of some food would have helped people make a more informed choice. For example, staff offered people soup but didn't say what type of soup it was. We saw that in one area of the home the food was plated up and shown to people so they could choose. A third person told us, "The food is not bad, it depends on the chef." A fourth person commented, "Breakfast is lovely and I enjoy the homemade soup. There is a lot of sponge and custard or semolina. I was asked for feedback on the food."

People told us and records confirmed that they accessed a range of health services. When needed people had been referred to the GP, SALT and other healthcare professionals such as a dietician.

The home was undergoing a decoration programme. Many of the main areas had been redecorated. Signage for people living with dementia had been provided in some areas and was due to be installed in other areas. People had access to safe gardens and grounds and could receive visitors in communal or private areas.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that capacity assessments and best interest decisions had taken place and were recorded. DoLS were also in place for some people living at Werrington Lodge. Staff had a good understanding of the MCA. One member of staff told us, "I did MCA when I did my induction. It is about the person knowing what they want and if they can express themselves, then they can make their own choices. If the person can't make a decision, we can always speak to the relatives to make the decision together." Best interest decisions were not always in place when needed for people using bed rails. This meant that other less restrictive options may not have been considered, such as a lower bed.

Good

Is the service caring?

Our findings

People and their relatives told us they thought that the staff were mostly caring. One person told us, "Oh yeah, the staff are kind. I can't find any fault with the staff." Another person said, "There are quite a few good carers and they are kind and caring." A third person said, "The interest the carers take in me is really good. I am a person and not a number and they don't just talk to me for health reasons." One relative told us, "The carers work really hard. The staff are kind and caring, it is just the lack of them. It can be very mixed care as it depends on who is on"

We observed lots of positive interaction between staff and people living at Werrington Lodge. One person told us, "We have a laugh and a joke [with the staff], it makes the day go quicker. They're [the staff] all polite." We saw that one person had become distressed and a member of staff who had come in to attend some training sat with the person and gave them reassurance. One staff member said, "I chat to people when I am doing personal care or supporting with a drink. I sing to people. We do read care plans and I will have a look before I support someone if I am not sure." We also saw in care plans that staff were instructed to allow time for people to become calm if they were anxious and to support people when they were ready. We saw that when one person woke up from sleeping in the lounge a staff member said hello and checked that they were okay. We saw that another person was cradling a doll and that the staff were respectful and asked if they could remove it as it was nearly lunchtime. The doll was removed gently and the person was happy to go to lunch.

Each day there was a "Resident of the day." Staff told us that the person was the focus of the day, for example, their care plans were checked with them to make sure they were still accurate. People told us that they could have visitors at any time and they were always made to feel welcome. We saw that staff referred to people by their preferred names. Staff had a friendly rapport with people they were working with and when they entered a room acknowledged the people in there and checked on their welfare. One person told us, "It's quite good here, quite nice. When I go into hospital I always like coming back."

Staff respected people's dignity and privacy. People confirmed that staff normally knocked on their bedroom doors before entering. We saw that people were asked for their consent before photographs were taken for their records. Personal care was provided in private with doors and curtains closed.

Staff told us they encouraged people to express their views and be involved in decisions about the care and support they received. One person told us, "Sometimes, the staff sit with me and ask me about the care. I have seen my care plan." Another person told us that staff had earlier discussed their blood pressure with them before recording the details in their notes. We saw that there had been a recent meeting for people who lived in the home to share their views or any concerns. At the most recent meeting the results from the "Residents' survey" carried out for people living in the home were discussed by the registered manager. Other subjects were also discussed such as the food, laundry and housekeeping, activities on offer and the amount of time it took staff to answer call bells. One relative said, "We used to be called in yearly to have a meeting but there was no meeting last year. We used to discuss the care with a nurse who knew my relative." The registered manager stated that friends and family meetings had been arranged and they would ensure

everyone was aware of forthcoming dates.

The registered manager had recently received a compliment letter from the family member of a person that lived at Werrington Lodge. The letter stated "[Family member] was calm and at peace and even stated that he felt safe. Not only did staff treat [family member] with the uttermost respect and dignity that they deserved, they provided him with care and compassion that a family member would give."

Staff working in the home's memory lane unit told us they wore polo shirts rather than a more formal uniform. They stated that this was because they hope it looked less austere for people living with dementia and improved how they perceived the staff.

People had been provided with information about advocates when they needed it. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection in September 2017 the service was rated as Good in responsive. At this inspection it had deteriorated to Requires Improvement. This was because people did not always receive person centred care.

Care records were not always an accurate reflection of people's current needs and were not always followed by staff. We saw that one person who was at risk of developing pressure ulcers was seated in the same upright position for at least five hours on the day of the inspection. Their care plan contained conflicting information and in one place stated that they should be repositioned two hourly and in another part of their care plan stated three to four hourly. The nurse told us that the person had been positioned on their right side earlier in the day but this conflicted with what we observed and the repositioning records which stated they had been on their back all day. Another person's care plan stated in one section that they should be having a pureed diet as recommended by the speech and language therapist but in another section stated that they should be having a fork mashable diet. One person's tissue viability plan stated that they could reposition themselves but in another section instructed staff to reposition them three to four hourly. Another person's care plan stated that they should have their call bell whilst in bed but their risk assessment stated that they could not use it.

The regional director stated that the care plans were reviewed regularly and if there were significant changes then the care plan was rewritten to include the most up to date information. However, we found that this was not always the case. For example, one person's care plan stated that they used a full body hoist and a sling when getting out of bed. However, when we talked to the nurse they stated that the person did not get out of bed anymore as it was not safe for them and had not done so for months. The care plan had recently been reviewed but the amendments had not been made to reflect the change. This put the person at risk of receiving care that was not based on their individual needs.

We found that important information was not always included in people's care plans. For example, one person had a seizure chart but no information in their care plan about having seizures. There was no guidance for staff about what to look for or what action to take. Another person's care plan stated that they had Parkinson's disease but there was no information about how this affected them or what action staff should take.

One relative told us, "Generally speaking, there is enough staff. Staff sometimes seem a little pressurised." Another relative told us, "There is not really adequate staff. They work flat out and do not have time to spend with the residents." A third relative told us that their family member did not receive assistance with personal care until 12.30pm as the staff told them they were "too busy". One member of staff told us, "There is enough staff on duty if there are six carers. There was only five this morning but the [registered]manager called in another member of staff." When we observed staff supporting people in the communal areas we found that time spent with people was focussed on assisting people with tasks such as eating and drinking rather that activities or social interaction. During our feedback the providers representative stated that they would consider staffing numbers, how staff were deployed and tasks allocated to help to ensure that people

received assistance from staff in a timely manner.

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

One visiting healthcare professional stated that staff made appropriate referrals to them and followed the advice given. They also stated that staff kept them up to date with any changes in the person's condition.

A weekly activities timetable was on display so that people knew what was on offer. The activities co-ordinator told us, "We do one to ones and try to do these everyday so people have some company. "One staff member said, "Sometimes people have enough to do but not everyone wants to participate. We do try and engage and encourage people." One person told us, "There's a lot of events and entertainment. An Elvis impersonator and other singers often come." We observed that when some people were watching television in one area of the home a nurse walked over and turned it off and put some music on without consulting them. One person said to us, "They don't consult, but I don't complain I just note it."

We received information from the relative of one person who had recently died in the home. They raised concerns that they felt that their family member had not received the support and care they needed in their final hours. Staff were able to tell us how they supported people who were receiving end of life care. One member of staff told us, "We make sure that person centred care is delivered. [For example] if they would like the radio or tv on. We provide mouthcare. We try to keep the area calm and peaceful. We support the families as well, we make sure they are comfortable as sometimes they might be scared. A [staff] can sit with the family at the time of the passing if they request. We support the family with food and drinks and when needed a shoulder to cry on." Staff received training on providing person centred end of life care. The registered manager stated that staffing levels are increased if someone is receiving end of life care and needs extra support.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection in September 2017 the service was rated as Good in responsive. At this inspection it had deteriorated to Requires Improvement.

There was a registered manager in place at the time of the inspection. However, they were not available on the second day of the inspection. Not all of the staff found the registered manager to be approachable. However, they stated that they felt that they could discuss any issues with other senior staff in the home or the regional director. One nursing team leader said, "I get enough support and things are better than the last inspection. I have regular supervision and enough training. Team meetings are held at least once a month and we discuss the residents."

There was a system in place to assess the quality of the service however it had not always identified the issues identified during this inspection. Although care plans had been regularly reviewed and audited the quality assurance processes in place were not always effective. Examples we found of this included, inaccuracies in care plans as well as medicines' records and medicines' administration. In addition, action plans had not always been created when audits had revealed areas for improvement. However, we saw that the regional manager had identified this during their regular quality monitoring visits and had taken appropriate action to deal with the issue.

Providers of health and social care are required to inform the CQC of certain events that happen in or affect the service. The provider had informed CQC of significant events. This meant we could check that appropriate action had been taken.

Staff received training on the home's visions and values during their induction and supervisions. One staff member said, "I think the service is well led. The residents seem happy and the carers are happy and we do our best to engage with people. If people were not happy they would complain. It is a nice home and we do our very best so they are safe and happy. We give our all and we are passionate about what we do." Staff told us that they worked together as a team but that communication could be improved. One member of staff told us, "Communication on all levels [needs to improve]." Another member of staff told us they would be happy to have a loved one living at Werrington Lodge, they stated, "They would get the care and the time (they needed) and patience [from care staff]."

Various meetings had been scheduled for the coming year. These included meetings about health and safety; also those for infection control, heads of departments, residents and relatives and lessons learnt. Staff told us that they could add to the agenda at meetings and that their views were taken into consideration.

Surveys were sent to people who lived at Werrington Lodge and/or their relative to ask about the quality of the care and support being provided. During the recent residents' meeting the registered manager had discussed their findings of the survey and what action had been taken when areas of improvement had been identified. There was also a "You said, we did" notice on display in the reception area informing people

about what action had been taken in response to the surveys. For example, when people had raised a concern about the choice of meals the chef had met with them to discuss their likes and dislikes so that the menu could be changed.

The registered manager told us that they and their staff team worked with other agencies such as the local safeguarding team. This helped to ensure that people were supported as they moved between services.

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 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always received their medicines as prescribed.