Barchester Healthcare Homes Limited

Wimborne

Inspection report

Selsmore Road
Hayling Island
Hampshire
PO11 9JZ

Tel: 02392467369
Website: www.barchester.com

Date of inspection visit:
17 August 2023
18 August 2023

Date of publication:
12 October 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Wimborne is a care home providing accommodation and personal care to older people and people living with dementia. The service can support up to 52 people. At the time of the inspection 41 people were living at the service.

People's experience of using this service and what we found
The provider failed to ensure people were supported with medicines safely.

Assessments were not always conducted comprehensively and on occasions were incomplete.

We could not be assured people were consistently protected from the risk of harm. This is because incidents had not always been investigated in a timely manner. Notifications were not always submitted to the local authority and CQC as required by law.

Whilst the provider had governance systems in place, these arrangements were not consistently effective at driving improvement and maintaining safety.

The provider was in the process of recruiting additional staff for various job roles. We observed effective staff deployment and people received their care and support at the times they required it.

The provider demonstrated actions were taken when concerns were raised.

People enjoyed a variety of activities and staff engaged positively with people. Relatives and people were complimentary about the care and support people received.

The provider had appropriate arrangements in place for the management of infection control.

Management were open and honest with us during and after the inspection and had submitted 7 notifications retrospectively.

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 the service was good and published on 11 September 2019.

Why we inspected
We carried out a focused inspection because we received information of concern relating to risk management and leadership within the home. We undertook this focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at

the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence the provider needs to make improvements. Please see the safe and well led key question sections of this report.

You can see what action we have asked the provider to take at the end of this report

Enforcement and recommendations
We have identified 2 new breaches in relation to safe care and treatment and governance.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

See our detailed findings below.

Is the service well-led?

Requires Improvement

The service was not always well led

See our detailed findings below.

Wimborne

Detailed findings

Background to this inspection

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

Inspection team
Four Inspectors, a Medicines Inspector and an Expert by Experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post. However, they were not available at the time of our inspection.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we held about the service including, notifications, complaints, feedback from stakeholders and quality assurance reports. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.
We used all this information to plan our inspection.

During the inspection
We spoke with the acting manager, the provider, the clinical development nurse, 10 staff members, 5 people

and 10 relatives. We obtained feedback from 5 health and social care professionals that worked closely with the service. We reviewed quality assurance records, various policies and procedures, training and supervision records, medication competency assessments and staffing records. We viewed investigation records and quality improvement plans.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Using medicines safely; Assessing risk, safety monitoring and management

- Guidance for 'as required' and variable dose medicines did not always include enough information for staff. Most lacked sufficient person-centred detail to support staff when administering these medicines. For example, information including when medicines should be administered, and the correct medicines dosage was not always documented. Additionally, we found 1 person's medicines records referred to another person. This meant there was an increased risk of medicines administration errors.
- Medicines were not consistently administered as prescribed or additional information sought from prescribers. For example, records indicated 1 person had received 1 dose twice a day rather than the prescribed 2 doses twice a day. Whilst 1 set of eye drops were labelled for "the affected eye(s)" and a further person was administered a when required medicine on a regular basis without a medicines review having been undertaken. Therefore, we were not assured that people consistently received their medicines as prescribed.
- One medicine prescribed for a person at the service was a risk to women of childbearing age. Staff were not aware of this when asked and were not taking the additional recommended safety precautions when administering this medicine.
- People's risks had not always been identified as part of their assessment process. Pre-admission assessments and care records had not always been fully completed therefore guidance to support people to stay safe were not comprehensive. This included the risks associated with people living with diabetes and anxiety related behaviour. Concerns about risk management plans were also shared by health and social care professionals we spoke with.

Systems had not always been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Medicines including controlled drugs were stored securely. Records showed medicines were stored within their recommended temperature ranges. However, the controlled drugs records were not always completed when medicine were returned to the community pharmacy for destruction.
- Medicines audits had been conducted. A recent audit had identified gaps in these records, resulting in a programme of staff training, competency assessments and additional focused audits.
- The provider was working with the local authority quality team to drive improvement in relation to risk assessment. They were focusing on strengthening falls management, equipment checks, recording, communication, and supporting people when they became distressed. This was confirmed by health and social care professionals we spoke with.

Systems and processes to safeguard people from the risk of abuse

● The provider had not always informed all agencies when safeguarding incidents such as possible abuse or harm had occurred. At the time of our inspection the provider was reviewing all safety incidents and notifying agencies retrospectively.

● Staff had received training and were knowledgeable about abuse. One member of staff said, "I attended the safeguarding training today. They covered everything about different types of abuse."

● The provider had implemented a 'speak up' champion who was available to speak with staff who needed to raise concerns.

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 MCA 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 when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Staffing and recruitment

● At the time of the inspection, the provider was in the process of recruiting activities coordinators, senior care staff, care assistants, domestic staff and a deputy manager. The provider used bank staff and existing staff from the home to cover any shortfalls.

● The provider had deployed sufficient numbers of staff to meet people's needs. During our inspection we observed staff responding to people's needs in a timely way.

● Staff were recruited safely and pre-employment checks were completed before staff commenced in post. These included Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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 supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● 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.

Visiting in care homes

● Feedback about the visiting arrangements was positive and all relatives said they felt welcome at the service.

Learning lessons when things go wrong

● As part of the provider's review of risk relating to falls, they said, "We are in the process of removing sensory mats because they pose a falls risk. Instead, we will be providing sensory alarms" and, "Through trend analysis, we identified [person] had most of their falls between 5pm and 7pm. We have adjusted staffing to respond to this."

Requires Improvement

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider's governance systems failed to identify statutory notifications were not always submitted to CQC in line with regulatory requirements. Seven historic safeguarding concerns had not been notified as required. The provider sent us these notifications retrospectively. Notifications are important as they inform us about notifiable events and help us to monitor services we regulate.
- Quality checks had not always been used effectively to identify shortfalls, errors and omissions. For example, checks had failed to identify assessments were not always completed and that comprehensive risk management plans relating to diabetic care were not always in place.
- The providers governance systems failed to recognise medication errors we identified during our inspection.

Systems to monitor risk and quality in the service were not always effective. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was taking action to address the quality concerns in the home. A clinical development nurse would be based in the home full time for the next 8 weeks. The divisional dementia specialist would visit the home for at least 2 days in the next 8 weeks to support improvement and the senior general manager would manage the home in the absence of the general manager.
- Other actions included objectives relating to activities, mealtime experience, recruitment, and dignity. We could see the providers response had positively impacted on people's experience and had improved the documentation.

Continuous learning, improving care and learning lessons when things go wrong

- The provider and acting manager acknowledged the home should have had better oversight to ensure the quality of care provided was to a higher standard. The provider said, "There have been lessons learned in terms of submitting notifications to CQC and the safeguarding team."
- The provider was actively working with the local authority safeguarding team to drive improvement in the home. Senior staff had been deployed from the provider to support the ongoing improvement of the service.

- Professionals said improvements were ongoing, however they feel improved communication and openness from the provider would aid progress further.

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

● At the time of our inspection we observed positive interactions between staff and people. People were provided with opportunities to participate in activities including ball games, singing and board games.

● We observed relatives visiting the home and staff were welcoming and friendly. We saw people smiling, laughing with staff and found the environment to be inclusive. People who remained in their rooms were monitored and provided with stimulation and effective care and support.

● Staff, relatives and people told us the culture in the home was engaging and positive. A member of staff said, "I think the home has had some issues and I do feel a bit anxious about the ongoing investigations but you can see people are well looked after here."

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

● During the inspection the provider and the acting manager were open and honest with us about the areas they felt required improvement. They acknowledged there had been a lack of oversight at Wimborne which had led to improvements being needed. The provider was in the process of implementing a new IT system and told us this would allow for more robust oversight and analysis of incidents, accidents and reporting.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Feedback from people, relatives and our observations suggested staff acted with kindness and treated people with dignity and respect. Comments from relatives included, "They have plenty of staff, activities going on, residents [people] seem to have fun", "The place was immaculate, very clean", "[person] "is happy there, likes the staff, food is good and likes her room which has a view of the garden and she can see the birds", "They [staff] are kind and caring – all staff seem caring."

● The provider had suitable systems in place for obtaining feedback from relatives, staff and people. This was done by means of a survey, through care plan reviews and through team meetings and staff supervisions.

Working in partnership with others

● The provider was in the process of working with the local authority and various healthcare professionals who were involved with the service. Comments from professionals included, "When the home has management on site this is very evident, and the home appears much calmer and in order for home to make and maintain improvements they need to have clear leadership going forward."

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people were appropriately supported with their medicines. The provider failed to ensure risk was consistently assessed, mitigated and reviewed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers governance systems failed to drive improvement in the areas we identified during our inspection.