Margaret Rose Care Limited

Warberries Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Warberries Nursing Home provides personal and nursing care to a maximum of 49 people. The service provides support to people who are living with dementia, and/or have nursing or residential care needs. At the time of our inspection there were 35 people using the service.

People's experience of the service and what we found:
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there was 1 person using the service who had a learning disability.

Risks to people were not always monitored and managed in a safe way, particularly risks associated with people's particular health needs. People's records did not always contain accurate, complete and contemporaneous information. Systems in place to safeguard people from abuse and avoidable harm, and to learn lessons from previous events, were not always effective. Although there had been improvements since our last inspection, the provider's systems did not always effectively monitor the quality of care provided to identify risks and drive improvements. This continued to put people at risk of harm.

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 supported this practice.

There were enough staff who had been trained, and during inspection we observed warm interactions between people and staff. Staff knew people well and could describe them and their care needs to us. People told us they felt safe, and relatives felt their family member was safely cared for. There were no restrictions on people having visitors.

People were well supported, and their privacy, dignity and independence was promoted. People were supported to express their views and be involved in making decision about their care. People told us "They are caring, they don't boss me around", "They are respectful, no hesitation".

There was a positive and open culture at the home. One person told us how they felt about the service, "I don't think you could improve on it, if you ask for anything they get it for you. They inform me of any issues." One family member told us they were, "kept up to date and the home call straight away if there are any concerns." The provider worked in partnership with others.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Requires Improvement 26 September 2022.

At this inspection, we found that although some improvements had been made, and they were no longer in breach of regulation 10 or 18, the provider remained in breach of regulations 12 and 17.

At our last inspection, we recommended the provider reviewed a certain element of staff training. At this inspection, we found the provider had taken action to review and amend staff training.

This service has been in Special Measures since 12 April 2022. During this inspection, the provider demonstrated that improvements had been made and is no longer rated Inadequate. However, the service remains in Special Measures due to persistent breaches.

Why we inspected
We inspected due to receiving concerns about an alleged incident of abuse. A decision was made for us to inspect and examine those risks. During our inspection, we found the registered manager had taken swift and appropriate action in response to discovering the abuse.

Enforcement
We have identified continued breaches in relation to regulation 12 safe care and treatment, and regulation 17 good governance.

Please see the action we have told the provider to take at the end of this report.

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.

Special Measures
The overall rating for this service is 'Requires improvement'. However, the service is remaining in 'special measures' due to the persistent breaches. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this time frame and there is a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is not rated as inadequate for any of the five key questions, it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	**Requires Improvement**
Is the service caring? The service was caring.	**Good**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

Warberries Nursing Home

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
The inspection team consisted of 4 inspectors, an assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using, or caring for someone who uses, this type of care service.

Service and service type
Warberries Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Warberries Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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 were 2 registered managers in post. One of them is known in the service as the registered manager, and is the person referred to in this report as the registered manager. The other registered manager is known in the service as the Clinical Lead.

Notice of inspection
The first day of inspection, on 21 November 2023, was unannounced. Our second day of inspection, on 23 November 2023, was announced. The inspection ended on 5 December 2023.

What we did before the inspection
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 10 people living at the service, 4 relatives and 8 staff including the 2 registered managers. We used the Short Observational Framework for Inspection (SOFI), in the dementia unit and the main home. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also reviewed a number of records about the governance of the service. This included quality assurance information, care plans and risk assessments for 13 people, medicine records, training and recruitment records and staff rotas. We made 3 referrals to the local authority safeguarding team, and we asked the registered manager to make 4 referrals as the result of our inspection.

After the inspection
We spoke with 5 more relatives on the telephone, and continued to review care plans and documents related to governance of the service. We spoke with 2 health professionals about 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 our last inspection we rated this key question Requires Improvement. At this inspection the rating has remained 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; using medicines safely
At our last inspection in June 2022, although there was no evidence of harm, the provider had failed to ensure risks associated with people's care needs were reduced. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the provider had made some improvements. However, we found additional concerns which meant there were continued breaches in regulation 12, which was their fourth consecutive breach of Regulation 12.

- Risks to people were not always monitored and managed in a safe way, particularly risks associated with people's specific health needs. People's records did not always contain accurate, complete and contemporaneous information.
- Although referrals were made to external professionals, the advice received was not always added to care plans. This meant staff didn't always have written updates on managing risk, although both registered managers said they had daily conversations with staff about their practices and people's care.
- One person received their food and fluid via a tube into their stomach (a PEG, or percutaneous endoscopic gastrostomy). Their care plan and risk assessment contained detailed guidance from the dietitian. However, records did not always demonstrate staff had followed the guidance. The provider could, therefore, not be assured the person was receiving sufficient fluids, which potentially placed them at an increased risk of dehydration. We shared our concerns with the local authority's safeguarding team.
- There were care plans in place for people living with diabetes. However, staff did not always record they were monitoring their blood glucose levels. The registered manager could not, therefore, be assured the person's condition was being managed safely. During inspection, the registered manager sent us a report from the blood monitoring device that showed staff were accessing the device to check the person's blood glucose levels.
- Risk assessments were in place for people at risk of choking. However, records were sometimes contradictory about the level of modified diet required. This put people at risk of being given the wrong level of food and drink, and of choking. We shared our concerns with the local authority's safeguarding team.
- One person was prescribed nutritional supplements twice daily to help them maintain a healthy weight. However, records suggested the person was not always receiving their supplements as prescribed placing them at risk of malnutrition.
- Improvements were required to ensure medicines were managed safely. Robust stock checking systems are necessary to ensure people receive their medicines as prescribed. We found discrepancies in medicine stock levels, including for an anti-psychotic medication, which put people at risk of harm.

● Some people were being supported with their continence needs and used urinary catheters. However, people's continence care plans did not contain detailed guidance for staff to recognise and prevent complications or infections. For example, actions staff should take to minimise risks and when to alert health professionals. This meant people may be at risk of harm from urinary infections and associated complications.
● People were at risk as action was not always taken in a timely manner. For example, 1 person was prescribed medicines to maintain regular bowel motions. Although staff had initially recognised the person was constipated, they had not taken further action for another 7 days, which put the person at risk of harm. We shared our concerns with the local authority's safeguarding team. On raising this with the registered manager they immediately contacted the person's GP for advice.
● Incident records indicated some people in the dementia unit expressed themselves in ways which staff sometimes found difficult to manage. Each person's care plan contained some information for staff to help them support people when distressed. However, there was not enough detail to ensure staff were consistent in their approach. This meant people were at increased risk of injury at these times. We asked the provider to make referrals to the local authority's safeguarding team about 4 people, which they did. We also asked the provider to review and amend these sections of care plans for everyone living in the dementia unit, which they did.

Although there was no evidence of harm, the provider had failed to ensure risks associated with people's care needs were monitored and managed in a safe way. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Two healthcare professionals we spoke to believed there needed to be improvements in the dementia care unit. One commented they saw "Some really lovely interactions" but both wondered if there was sufficient knowledge conveyed by the registered manager to the care staff about supporting people with advanced dementia. Both teams were happy to provide future support, acknowledging the home supported some people with very complex needs.
● Staff knew people well and could describe them and their care needs to us.
● One relative told us, "The staff know what they're doing" and had picked up very quickly when staff believed their family member to be experiencing a potentially serious health event. Another relative told us, "My [family member] is safe, I've no concerns at all."
● One person told us, "There are always 2 of them if I need hoisting." Another told us, "I've got a PEG, the staff know what they are doing with it."
● There were systems and processes in place for storage, recording and disposal of medicines. This included those needing cold storage and those needing extra security.
● When medicines were prescribed to be given 'when required' there was guidance in place on the electronic medicines record to guide staff when doses should be given.
● Staff received training in safe medicines handling and had competency checks to make sure they gave medicines safely.
● Medicines audits were completed by the registered manager, to identify any improvements needed.

Learning lessons when things go wrong; systems and processes to safeguard people from the risk of abuse and avoidable harm
At our last inspection, in 2022, there was no system to help identify themes and trends in relation to incidents, which meant there was a continuous breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, the provider had made enough improvement and was no longer in breach of this element

of regulation 17.

At our last inspection, in 2022, the provider had failed to ensure people were safe from abuse and improper treatment, which was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, the provider had made enough improvement and was no longer in breach of regulation 13.

● The provider had made some improvements to the way they learned lessons when things had gone wrong. They had also identified, and acted on, concerns which needed to be referred to the local authority safeguarding team.
● However, this system was not fully embedded and did not always work effectively. For example, we asked the registered manager to make 3 safeguarding referrals about errors in record keeping relating to people's health. We also asked the registered manager to make 4 safeguarding referrals for people living in the dementia unit. Although there was training for staff and care plans in place, the plans were not detailed enough to ensure staff responded consistently to people expressing distress. The registered manager took immediate action to reduce risk in response to our concerns.
● Since our last inspection, in 2022, systems had been put in place for reviewing incidents and accidents. The registered manager had daily oversight of these and took action as required at the time, for example, referring the person to a health professional. They also analysed the information on a monthly basis to look for themes and trends.
● Staff received safeguarding training at the time of inspection.
● Staff we spoke understood what sort of things might constitute a safeguarding issue. They told us they knew how to report concerns, and how to escalate them inside and outside of the service, for example, to the local authority.

Staffing and recruitment
At our last inspection, we recommended the provider carried out a review of training for managing behaviours that might challenge others. At this inspection we found the provider had acted on this recommendation. For example, introducing breakaway and conflict resolution training which staff told me they had not received before.

● The provider ensured there were sufficient numbers of suitable staff.
● Staff rotas we reviewed indicated the provider's assessed staffing levels were met. There were consistently high numbers of staff. We also observed many staff on shift, including during our unannounced visit.
● Most people, and their families we spoke with, told us there were enough staff. One family member told us there was, "Always someone to help, [relative] is not left waiting." Another relative told us, "Staff are patient, they sit next to her and reassure [person]." One person told us, "It doesn't take too long to answer the bell when I ring it."
● The provider operated safe recruitment processes.

Preventing and controlling infection
● People were protected from the risk of infection as staff were following safe infection prevention and control practices.
● Clearly visible Personal Protective Equipment (PPE) stations were distributed around the home. We also observed staff wearing appropriate PPE at the time of our visits.

Visiting in Care Homes

- People were able to receive visitors without restrictions in line with best practice guidance.
- The registered manager confirmed visitors were welcome at times and frequency which met the person's, and the visitor's, requirements.
- We observed relatives were present and spoke with 4 family members whilst we were in the home.

Is consent to care and treatment always sought in line with legislation 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 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS)

- The provider was working in line with the MCA.
- People's capacity had been assessed, for example, about the use of CCTV. Best interest decisions, involving people's families, had been taken where the person did not have capacity to make the decision.
- DoLS applications had been made where a person was assessed to lack capacity about their accommodation, and was being deprived of their liberty in their best interests.

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.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Good. This meant people were supported and treated with dignity and respect. They were involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity; respecting and promoting people's privacy, dignity and independence
At our inspection, in 2021, the provider had failed to ensure people were always treated with dignity and respect or always involved in their care. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider had made enough improvements and was no longer in breach of Regulation 10.

At our last inspection the provider had failed to operate effective systems and processes to support the confidentiality of people using the service, which was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider had made enough improvements and was no longer in breach of this aspect of Regulation 17.

- People were well supported, and their privacy, dignity and independence was promoted.
- We observed kind and caring interactions between people and staff, and people seemed comfortable and relaxed around staff. People told us, "They are caring, they don't boss me around", and "They are good at encouraging me to use my walking frame." Family members told us, "The care is good, [family member] is always well dressed and clean", and "The staff are very respectful in the way they talk to [relative]."
- We observed meal tables set with linens, crockery and where appropriate according to their individual requirements, glasses. People were offered meaningful choices of food and drink. For example, 1 person was having wine with their main meal of the day.
- People's bedroom doors were open or closed according to their personal wishes, and to maintain their dignity.

Supporting people to express their views and be involved in making decisions about their care
- People were supported to express their views and be involved in making decision about their care.
- There were systems in place to gather and record the views of people who might not be able to attend residents meetings. Family who were present at the time were also asked their views. Changes were made as a result of issues raised at residents meetings. For example, people had asked for more activities, so an extra activity co-ordinator had been employed. One family member told us, "There are more activities", and they

could, "See the difference in [their relative]." They also told us, "There have been beautiful moments with groups of residents outside in the summer."

● People and their families were consulted about their care plans. People were asked about their care on a daily basis. Most relatives we spoke with told us they were involved in the care of their family member and were kept informed about what was happening with them. However, 2 relatives told us they had not been asked about their family member's care plan.

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 Inadequate. 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; continuous learning and improving care
At our last inspection we found the lack of effective governance and oversight of the service placed people at harm. This was the third consecutive breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the provider had made some improvements. However, they were still in breach of regulation 17.

● Although there had been improvements since our last inspection, the provider's systems did not always effectively monitor the quality of care provided to drive improvements.
● The governance systems in place had not always identified risks associated with inconsistent record keeping in the management of people's health conditions and of people's medicines.
● Processes hadn't always identified when further action should have been taken to ensure people's health conditions were escalated appropriately, even when records had been kept consistently.
● Governance systems in place had failed to identify the lack of detailed enough information in care plans for staff to safely manage some elements of people's care. For example, continence, and times when people experienced high levels of emotional expression.
● Quality assurance systems had not always identified that care plans sometimes contained contradictory information, for example, about the level of modified food or drink required to reduce their risk of choking.
● The system in place had not always ensured care plans were updated with new information from external health professionals. This meant there was a risk key information to meet people's assessed health needs was not communicated to staff.
● The medicines auditing system had not identified discrepancies in medicine stock control.
● The registered manager had not ensured CCTV usage was in line with CQC guidance and other regulatory requirements. For example, signage was not clearly displayed and people's privacy was not always assured.

We found no evidence people had been harmed. Although improvements had been made since our last inspection, more effective governance processes were required to monitor the safety of the service. This was the fourth consecutive breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in 2022 the provider had failed to notify CQC of significant events which was a breach

of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At this inspection the provider had made improvements and was no longer in breach of Regulation 18.
● The provider had notified CQC in full about any notifiable events at the service in line with regulatory requirements. We use this information to monitor the service and ensure they respond appropriately to keep people safe.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People and staff were involved in the running of the service and fully understood and took into account people's protected characteristics. There was a positive and open culture at the service.
● One person told us how they felt about the service, "I don't think you could improve on it, if you ask for anything they get it for you. They inform me of any issues."
● Staff told us there were regular and frequent staff meetings where matters were discussed. Staff were also sent a survey every 6 months and provided feedback on the service. Staff meeting minutes showed staff being updated and also areas highlighted where improvements needed to be made.
● Staff we spoke with were very positive about the new registered managers and the improvements which had been made during their time in post. For example, 1 staff member told us, "Now we have so much more support and a lot of things have got better due to [the registered managers]." Another told us, "We can ask for anything and we can contact [registered manager] any time of the day or night.
● Some relatives we spoke with told us they had been asked for feedback in a survey. One relative told us there were forms at the front door to provide feedback, and that they were asked for feedback on the electronic system as they signed out. Relatives who hadn't been formally asked for feedback felt confident about raising issues with the registered managers. One family member told us they were "kept up to date and the home call straight away if there are any concerns."

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;
● The provider understood their responsibilities under the duty of candour.
● Appropriate Statutory Notifications were made to CQC. These are notices registered providers must send to notify CQC about certain changes, events and incidents that affect their service or the people who use it.
● The registered manager was open with us during the inspection. They recognised that further improvements were needed and demonstrated a willingness to listen and improve by making changes and acting on areas of concern we identified.

Working in partnership with others
● The provider worked in partnership with others.
● Advice and support was sought from a variety of health and social care professionals who were involved with people living at the service, and advice sought. For example, dieticians, district nurses, and the Community Health Education Service.
● One healthcare professional told us the registered manager worked openly with their team, and was response, saying, "Everything he's asked to do he's done." Their view was that although there were still some improvements to be made, the registered manager had made improvements to the service since they had been in post.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured risks associated with people's care needs were always monitored and managed in a safe way.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	More effective governance processes were required to monitor the safety of the service.

The enforcement action we took:

Warning notice served.