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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Warberries Nursing Home ("Warberries") was a residential care home providing personal and nursing care to 30 people aged 65 and over at the time of the inspection. The service can support up to 49 people.

Warberries is an adapted older building with a newer extension. People live across three floors. One section, referred to as "the unit", specialises in providing care to people living with dementia.

People's experience of using this service and what we found

This inspection highlighted the service carried out some tasks well, but there were also concerns about people's safety and how the service was being governed. People were positive about the care they received however, feedback from families and staff was mixed.

The registered manager and provider had ensured some systems of oversight were in place to review the service, identify issues and ensure these were addressed. However, some additional audits were needed for example in relation to falls and disposal of some waste. Staff told us they had identified concerns and made suggestions to improve the service and people's care, these were not always responded to.

People living with dementia were not always safe from the actions of other people living alongside them. Some people found it difficult to communicate their needs and concerns. The provider had arranged some training for staff, but this had not been delivered due to the pandemic. Staff would benefit from training around different ways of communicating with people. In the months following the inspection, the registered manager has provided evidence to show what actions, alongside other professionals, has been taken to support people be safer in each other's company.

People were at risk of harm from poor medicines systems and processes.

People's health needs and associated risks were not always identified, assessed and mitigated. Where records of risks were in place, some of these had not been updated in line with the provider's required programme or when adverse events, such as a fall, took place.

In general, good practice was being followed in respect of infection control and the home had not experienced an outbreak of Covid 19. Further improvements would enhance the good practice observed.

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 Good (the last report was published 12 December 2018). This has now deteriorated to Requires improvement. This is based on the findings at this inspection.

Why we inspected
We received concerns in relation to the management of medicines, the safety of people living with dementia, falls and the clinical management in the service.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Warberries Nursing Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment and, in respect of leadership and governance.

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.

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.

Is the service well-led?

Requires Improvement

The service was not always well-led.

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 Care Act 2014.

This was a focused inspection completed due to concerns we had received.

As part of this inspection we also, 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 onsite inspection team was made up of an adult social care inspector, a member of CQC's pharmacist team, a nurse specialist and an assistant inspector. An Expert by Experience made phone calls to people living at The Warberries and some relatives. 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 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 the inspection

Prior to the inspection we reviewed the information available to us on our systems and, communicated with the local authority as they had shared a number of concerns. We used all of this information to plan our inspection.

We asked for additional information to help inform our judgements during the inspection process.

During the inspection
The team reviewed the care of 13 people. As part of this, we looked at how their care was planned, how their clinical needs were being met, how people were supported to receive their medicines safely. We were not always able speak with people due to their complex needs. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with three people living at the service and 16 families over the telephone.

After the inspection
We contacted staff and professionals with knowledge of the service to seek their feedback. We received six staff responses. We spoke with a GP and received written feedback from a dietician.

We continued to seek, and review evidence provided by the service in respect of people's care and how the service was being governed.

We communicated with the local authority's adults safeguarding team, quality assurance team and local fire service and shared information with them about our concerns.

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 now 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.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management

● Prior to the inspection, we had concerns raised with us about how some people's behaviours associated with dementia, were being managed, how this might be putting some people at risk of harm and about peoples experience of falls. Although most of the people and relatives told us they felt it was safe living at Warberries, we identified some concerns which put people at risk of harm. For example, one family member we spoke with told us they did not feel their family member was safe due to regular falls and the risk of harm from other people living at the home.

● Staff told us they didn't always feel they and people were safe and, felt management did not act to keep people safe when they raised concerns. One staff member said, "I would tell my manager, but I don't feel confident that people will then be kept safe."

● Following our inspection, we shared our concerns with partner agencies.

● On inspection we found, risks were not always identified or properly assessed. For example, where people had fallen, risk assessments were not always updated, not all falls were recorded and, observations were not consistently completed

● Where people had specific health needs their care plans did not contain sufficient detail to enable staff to provide appropriate care. For example, a person had a history of cellulitis affecting their legs. No further details were provided to staff on how to manage this condition. Prescribed creams were not being recorded as being used. This person had developed an infection requiring antibiotics in November 2020 however, until we highlighted the gaps in their care this had not been reflected on.

● Where people had specific health issues their care plans did not have sufficient details to support staff on the actions, they should take to reduce the risk of harm. One person was diagnosed with epilepsy. Their care plan had no details about the duration of any seizures, when to administer prescribed medicine to stop the seizure or when to call for emergency support. The care plan simply stated, "give rescue medication".

● A person living with diabetes, who relied on staff to meet their needs, had a detailed care plan written with the diabetes specialist team but actions in the care plan were not always followed. Medication administration records (MARs) showed that insulin was not administered as prescribed on 10 November and 12 November 2020. Additional monitoring was not recorded when blood sugar levels were high to ensure people remained well and concerns could be responded to quickly.

● A person had a percutaneous endoscopic gastrostomy (PEG) through which they received their nutrition and medicines. Their care plan did not have adequate detail to ensure their need could be met safely. For example, how staff were to look after and safely administer medicines via the PEG. We have shared this information with our partner agency for follow up.

● The training records did not show that staff had received sufficient training. The registered manager and

the provider accept there have been issues with ensuring staff completed training, supervision and checking competencies. This has been made more difficult due to the lack of training available since the pandemic started.

●The premises were not always safe. Fire safety measures were in place but, it was noted that two fire exits would pose a risk should the home require evacuation. For example, one exit was not accessible, this was addressed during the inspection. We have advised the fire service of what we found. The fire service has advised they have been in contact and offered advice. Access to the sluice and laundry were not secured effectively to prevent unauthorised access. The provider reported all windows are restricted and that all heated surfaces are fully covered. There was no system in place to ensure the restrictors and heated surfaces continued to be safe. Alarm cords in communal bathroom and toilets were raised too high, so if someone fell, they would find it difficult to call for help and support. We raised these concerns with the registered manager at the time of the inspection, they assured appropriate action would be taken.

This evidence demonstrated a failure to ensure people received safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We completed a SOFI observation on the dementia unit which showed people at that time were content and happy in staff's care.

● The GP, we spoke with was happy that the service contacted them appropriately and in good time. Their records also showed that the service contacted the out of hours provision often.

Using medicines safely

● Prior to the inspection, we received concerns there had been medicine errors. The local authority medicine optimisation team had visited the service to assess and give advice. However, we found people's medicines were not always safely managed.

● People did not always receive their medicines as prescribed. For example, a person at high risk of constipation and another's insulin. This placed people at risk of harm.

● Where people were prescribed 'when required' (PRN) medicines, it wasn't clear when staff should give these medicines and how to assess the dose to give. For example, the care plan for one person described how they were unable to say if they were in pain. A description of the person's body language was included but this did not indicate different levels of pain and no pain assessment tool was used. We also noted their analgesic was nearly always given at the maximum dose. Neither the reason for administration nor the effectiveness of the medicine was consistently recorded.

● Some medicines administration records were handwritten but didn't contain the required details. For example, that medicines may make people drowsy. Records were not always updated to reflect changes in medicines.

● Some people who were at risk of skin damage as they did not always have their creams applied as prescribed. For example, records showed one person had a barrier cream applied only eight times in 22 days. Staff said that creams were not always applied and recorded accurately.

● One person's medicine administration record (MARs) included three pain killers that contained paracetamol, which according to their records could be given at the same time. The MARs showed that staff administered doses within the safe range, but the risk that too much paracetamol could be given had not been identified.

● Medicines training records did not show all staff who administered medicines had completed their training or when. The registered manager told us that they checked to make sure staff were competent to administer medicines at least once a year. However, records showed only three care staff had been checked as competent to administer medicines.

● Medicines stored in the fridge may not have been effective as some of the recorded temperatures were

outside of the safe range.

Not ensuring medicines are properly and safely managed is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● This home had not experienced any infection outbreaks in the last year. In general, good practice was being followed. Further improvements would enhance the good practice observed.
● Most staff wore masks throughout the inspection. However, when in the office, staff, including the registered manager, did not always wear masks. We discussed the latest government guidance during the inspection.
● Waste bins for discarded PPE were not available in all areas on the first day of inspection, although these had been increased on the second day, the contents were not being treated as contaminated waste. The sluice room was unlocked, and some bins did not have lids or foot pedals to reduce the risk of spread of infection.
● People's own shavers were being stored together and, communal grooming sets were used. This presented an increased risk of cross contamination.
● Policies in respect of infection control were in place, and new policies had been brought in respect of coronavirus.

Not ensuring effective infection control is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● 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.

Learning lessons when things go wrong
● The service reviewing accidents and incidents for individuals and, reported these to the local authority. For example, when people fell. However, when we asked the registered manager how they learnt from these individual falls in order to keep others safe, they were not able to provide evidence of this. Staff told us they completed incident reports, and these went to management. However, there was no feedback on how the same situation could be prevented in the future.
● Following the inspection, the provider advised they had installed from June 2020 onwards "Altertamats" for the floor and chairs. These being wireless, reduce the likelihood of people tripping over wires. This they described, was from learning from falls in an attempt to improve the situation for people.

Staffing and recruitment
● Although we received some mixed feedback about staffing levels, our observations showed staffing was sufficient to meet people's needs and call bells were answered in a timely way.
●The registered manager had systems in place to assess what staffing was needed and sought to ensure this staffing was provided.
● Staff were recruited safely. Staff said, "Our policy is, we are assured for staff to shadow with one satisfactory reference and DBS (Disclosure and Barring Service) and, we will continue to chase for outstanding references. If I do not hear via letter or email, I will then phone and get a verbal reference."

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 the last inspection this key question was rated as Good. At this inspection this key question has now 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.

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

- This inspection highlighted that the service was doing some things well, however also when there were concerns.
- We received mixed feedback about the culture in the service. Some people didn't know who the manager was, but this may be because they hadn't been able to visit the service due to the pandemic. We did note that during the inspection the manager and deputy manager spent much of their time in the office. They were unaware of the issues we had found, and one staff member thought it would help to have a more involved management team. The registered manager advised that the increase in their workload meant they needed to be office based more often, but she would look at how this could be improved between the deputy manager and her.
- Family and staff gave us mixed views about how they were involved in supporting developments within the service, and in respect of people's changing needs. Families who had known the service prior to Covid 19 could identify having been asked to complete a questionnaire in the past and had been invited to attend meetings.
- Staff, either gave a very positive picture of how the service was being run or were very negative. Staff told us, and the registered manager confirmed, that some staff had shared worries with management, about their concerns and these had not been addressed. A staff member said, "Staff are not supported or listened to, any suggestions are generally ignored". Another staff member said, "The home has had a couple of managers and temporary managers. [The registered manager] has been a beacon of light since she started [in February 2020]. She has thrown herself into the running of the home with a passion."

Continuous learning and improving care; Working in partnership with others

- The provider stated they would continue to work with other agencies to help support learning and improvements. However, systems and processes could be improved to ensure continuous learning and improving care.

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

- The registered manager and provider had ensured some systems of oversight were in place to review the service, identify issues and ensure these were addressed. However, some additional audits were needed, for example in relation to falls and disposal of some waste. In respect of medicines, the audits had also not identified when staff did not work according to the provider's medicines policy. For example, checking that

medicines given covertly were safe to be mixed with food or accuracy when handwriting MARs.
● Staff told us they completed incident reports when either people or staff were harmed. Some staff felt that the information in incident reports was not always used to manage the risks identified. Some staff felt their concerns weren't always listened to. We have shared this information with registered manager.
● The service was had a registered manager who was supported by a deputy manager and a care supervisor.
We found roles and responsibilities were not always clearly defined or overseen to ensure they were delegated tasks were being completed. For example, when concerns were raised during the inspection, the registered manager advised us that this was the responsibility of a different member of staff to them. This took place in respect of whose responsibility to keep care records up to date. Also, in ensuring fire safety and checks of the fire exits were completed.

This demonstrates a failure to continually assess, monitor and improve the quality of the service. This is a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Two staff told us, they felt supported and confident to give feedback and felt this would be accepted; others did not. One staff member said, "I have made suggestions about the needs of some people who need further assistance, such an extra member of staff. This has been ignored" and another, "The staff, including myself, have many times been to speak to management for guidance and support, but it just isn't there. The staff have been pushed to their limits and a lot have left due to this."

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 Regulation 12(1)(2)(a)(b)(c)(d)(g)(h) Care and treatment was not always provided in a safe way for people. Risk to people's health and safety were not always assessed and all was not done to mitigate such risks. Staff did not always have the right training, competence and skills. Medicines were not always safely managed. The service was not always ensuring infections, including those that are health care associated, could be prevented.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1)(2)(a)(b) Systems and processes had not been and established and operated effectively to: Assess, monitor and improve the quality of the service. Assess, monitor and mitigate risks relating to the health, safety and welfare of people.