Care Quality Commission

Barchester Healthcare Homes Limited

# Winchester House

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
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|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

About the service
Winchester House is a care home registered to support up to 123 people with nursing and care needs. It is divided into five communities. One community was for people with complex nursing needs and two were for people with dementia nursing needs. The home also had two residential communities for people without nursing care needs, one of which was a residential community for people living with dementia. At the time of our inspection 120 people were living at Winchester House.

People's experience of using this service
People told us and our observations confirmed their experience of care was negatively effected by the staffing levels within the home. People told us there were not enough staff and we found staffing levels were based on inaccurate dependency assessments.

The provider had recently changed their corporate admissions policy. Prior to this Winchester House had made local changes to their admissions process. This was in recognition that they had admitted people whose needs they were not able to meet. People were at risk from each other and did not always feel safe. The measures in place to mitigate risks faced by people were not effective and were not updated after incidents. There was not enough information available about people's medicines.

People's preferences were not captured in their care files, including their wishes for their support should they reach the last stages of their life. Records of care were task focussed and did not show that people's choices and preferences were being respected. 

The governance systems in place had identified there were shortfalls in the quality of care plans and risk assessments. They had not identified the dependency assessments were not being used correctly. Despite issues with the quality and safety of the service being well known by the provider, the actions in place had not been effective in driving improvement.

People and relatives told us there had been recent improvements in the activities provision within the home. However, this was not yet being felt by everyone in the home and some people still felt bored. Some people were able to access representatives of their faith and attend religious services.

People's experience of mealtimes varied and some relatives felt they had to attend at mealtimes to ensure their family members got the support they needed to eat their meals. People were not always offered choices.

People were supported to attend healthcare appointments and access external healthcare professionals and other agencies. It was not always clear that the advice of these professionals was incorporated into people's care plans.

People were supported to take their medicines as prescribed. People and relatives knew how to make complaints, however, they did not feel issues raised were always resolved in a timely way.

Staff were given the training and supervision they needed to perform their roles, and people told us they thought staff were working hard. However, staff had not received specialist training in supporting people with complex needs related to dementia.

People were not always supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection:
The last rating for this service was good (published April 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to Person Centred Care, Safe Care and Treatment, Staffing and Good Governance at this inspection.

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 for 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 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.

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| **Is the service safe?**<br>The service was not always safe.<br>Details are in our safe findings below. | **Requires Improvement** |
| **Is the service effective?**<br>The service was not always effective.<br>Details are in our effective findings below. | **Requires Improvement** |
| **Is the service caring?**<br>The service was not always caring.<br>Details are in our caring findings below. | **Requires Improvement** |
| **Is the service responsive?**<br>The service was not always responsive.<br>Details are in our responsive findings below. | **Requires Improvement** |
| **Is the service well-led?**<br>The service was not always well-led.<br>Details are in our well-Led findings below. | **Requires Improvement** |

Care Quality Commission

# Winchester House

**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.

Inspection team
The inspection was carried out by one inspector, a specialist advisor who was a nursing expert, two assistant inspectors and a directorate support coordinator. Two experts by experience supported 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.

Service and service type
Winchester House 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.

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
We reviewed the information we already held about the service. This included information submitted to us as notifications. Notifications are information about events which providers are required by law to inform us about. We reviewed the feedback we had received from members of the public, and local authority commissioners who were involved with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took

this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 20 people and 12 visitors including friends and family of people living in the home. We spoke with 15 members of staff including the registered manager, the regional director, two deputy managers, the chef, an activities coordinator, two nurses, four health care assistants, two team leaders and one care practitioner. We also spoke with three visiting health care professionals. We reviewed the care records of ten people who lived in the home, and medicines records across all the communities. We reviewed the recruitment records for ten staff including their supervision records as well as the training records for all staff. We reviewed various meeting records, audits, and other records relevant to the management of the service.

After the inspection
We received further information and clarification from the provider to help us make our judgements.

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.

Assessing risk, safety monitoring and management
● Risks faced by people had been identified, but measures in place to mitigate them were not effective in reducing risks of harm. The service did not respond to changes in people's presenting risks in a proactive way.
● The provider used a range of assessments to identify risks faced by people in relation to their mobility, moving and handling, skin condition and pressure wounds. However, the measures in place to mitigate risks were not personalised and were not amended to reflect changes in people's needs.
● For example, one person was identified as being at high risk of falls. Despite measures being in place to mitigate this risk, the person had continued to experience a high number of falls. Although the incident reports all stated the risk assessments had been reviewed and amended, there were no recorded changes to the risk assessment. The provider had not considered any alternative measures that could have reduced the risk of this person falling.
● Another person was identified as being at risk due to their refusal of personal care. The measures in place were not sufficient to mitigate these risks. They described that staff should approach the person "gently" and tell them what was going to happen, but did not describe any personalised approaches that would facilitate this person having personal care.
● Clinical risk assessments lacked detail. For example, a stoma care risk assessment did not include the type of stoma bag used. Likewise the type of catheter used was not described in the relevant risk assessment. In moving and handling risk assessments, the exact equipment was not specified. For example, sling size and type was not always described.

Using medicines safely
● People received their medicines as prescribed. However, there was not always enough information about people's medicines or the support they needed to take them to ensure medicines were managed safely.
● The provider told us the reasons why people's medicines were prescribed, as well as the risks, side effects and how they should be supported to take them should be included in care plans relating to the health condition for which the medicines were prescribed. These care plans were not present in any of the care files we reviewed.
● Staff relied on the prescription instructions included on the medicines administration records (MAR) to know why and how to administer medicines. As some medicines can be prescribed for different health conditions, this meant there was a risk that staff who were less familiar with individuals may not know why they were prescribed specific medicines.

The above issues with risk assessments and medicines information are a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw a member of staff took a telephone call while giving a person their medicines. This meant they were not fully paying attention to the person and was not dignified or person centred. They took this call despite wearing a tabard that advised their colleagues not to disturb them. We informed the registered manager and regional director who told us they would remind this staff member about best practice during medicines administration. Other observations showed staff usually supported people to take medicines kindly and sensitively.
● Where people were prescribed medicines on an 'as needed' basis there was clear information for staff to help them know when to offer and administer these medicines.
● Medicines were stored safely and appropriately. We found some missed signatures for the day of the inspection, the member of staff immediately identified this was a recording error by doing a full stock count for these people's medicines. All other medicines records were fully completed.

Staffing and recruitment
● People told us there were not enough staff available to meet people's needs. For example, one person said, "I don't think there are enough staff, only one carer on most of the time." Another person said, "Not enough staff on to help when I need the toilet."
● Relatives described having difficulties finding staff to help them support their family members. We noticed on one community that a large number of relatives arrived just before lunch and supported their family members to eat. They told us they found their relatives didn't get the support they needed to eat their meals if they did not provide it. Staff told us they often worked with fewer staff than they needed.
● We observed breakfast in one of the dementia communities. The impact of the low staffing levels was clear. One person had finished their breakfast and wished to leave the dining area. However, they required support from staff to mobilise. Staff had to ask them to remain seated in the dining room several times over the course of 15 minutes as there were not enough staff to support them to mobilise. At lunchtime on another community people were still sitting in the dining area 45 minutes after finishing their meals as staff were supporting people to eat in their bedrooms.
● Staffing levels were calculated based on the provider's dependency assessment which relied on combining the individual dependency assessments completed for each person. These had not been completed accurately and under-represented people's needs.
● For example, one person's skin care plan identified they were at high risk of skin damage. Their skin needs were coded as a medium need on their dependency assessment. Another person's care plan identified their communication put them at risk of harm however, communication was coded as a medium need on the dependency tool. The regional director acknowledged this person's communication should have been scored as a high. This meant the overall dependencies had under-estimated the needs of people and resulted in insufficient staff numbers being calculated.
● The overall dependency assessments were not always met on the rota. For example, on one community there should have been two healthcare assistants (HCA) on duty in the morning, and one in the afternoon. The rota for November 2019 showed four occasions where only one HCA was scheduled all day. In another community the dependency assessment said there should be seven HCAs in the morning and six in the afternoon. For the week between 4 and 11 November 2019 the rota did not meet this on any day showing one fewer HCA was scheduled each morning and on four afternoons, with one day's schedule short of two HCAs in the morning.
● On the second day of the inspection we observed staff were under significant pressure in one community due to the nature of people's needs and needed additional staff to support people. In response to this feedback, staff were re-deployed. However, this left another area of the home with only one HCA, when their

dependency assessment said they needed two. This meant there were not enough staff available to meet people's needs.

The above issues with staff deployment are a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The regional director told us they would provide additional training to staff completing the dependency assessments to ensure they were an accurate reflection of people's needs.
● Recruitment records were not always completed in a way that demonstrated staff were assessed as suitable to work in the service. Interview assessments were not always completed. Furthermore, one member of staff was subject to an individual risk assessment but the registered manager told us this had not been written down. This meant it was not always clear systems ensured staff were suitable to work in the home. The registered manager ensured these records were completed in response to our feedback.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People and relatives did not always feel safe. One person said, "I don't feel safe, especially if they [other people who live in the home] take over vocally or just jump in front of you." There were a high number of incidents where people who lived in the home abused each other. The risks of this were identified in individual risk assessments, but the measures in place to mitigate this were generic and had not effectively reduced the number of incidents which occurred.
● Staff demonstrated they understood safeguarding processes and how they should respond to allegations of abuse. Staff knew to intervene to keep people safe and report allegations to their managers and the local authority.
● Staff completed incident forms and reported concerns that people were being abused to the appropriate authorities. Records showed the provider cooperated with investigations into allegations of abuse.
● However, measures to prevent recurrences of incidents of abuse were not robust, and did not ensure people felt safe. For example, one person was identified as being at high risk of being abused due to the nature of their communication. Staff were instructed to, "provide reassurance" and, "redirect [person] from other residents" in addition to administering medicines but this was not effective in reducing the vulnerability of this person to abuse from others.
● Incident reports included details of actions to be taken to prevent the likelihood of recurrence. However, these actions were not always completed, and learning was not consistently applied to related situations to share learning.

Preventing and controlling infection
● There were systems in place to ensure the effective prevention and control of infection.
● There were cleaning schedules in place and we saw these were being followed.
● We noted there was intermittent mal-odour in a specific area of the home. This had previously been noted by the provider's audits and there were systems in place to monitor and address these issues.
● There were systems in place to ensure the risks of cross contamination with laundry were mitigated. Staff described how they ensured clothes and bedding were washed appropriately. However, several people and relatives raised they found clothing went missing from the laundry.
● We saw appropriate personal protective equipment was available for staff and was used appropriately during the inspection.

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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 the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider used a range of assessment tools to assess people's needs and choices before they moved into the home. However, these had not always been used effectively to identify whether the service was able to meet people's needs.
● The provider had identified that the assessment tools were not always being used effectively and had recently changed their assessment criteria and policy. The provider recognised that they had previously admitted people to Winchester House whose needs they were not able to meet. In future they planned they would not admit people with complex needs relating to dementia.
● The assessments which had been completed had considered people's medical and life history, but details about their choices which would ensure they received person centred care in line with guidance had not been collected. It was not clearly recorded that people and their family members, where appropriate, had been involved in completing the assessments and writing the plans to meet their needs.
● As described in the safe domain, there were multiple incidents between people living in the home. The assessment process had not considered the potential interactions between people when living together, ahead of them moving in. In one case, the referral information and handover from the previous care home, included very detailed information about the issues that had led to the incidents at Winchester House. This meant staff had not used information available to them at the point of assessment.

Staff support: induction, training, skills and experience
● The provider had systems in place to ensure staff had training in specified areas they required. There was a system in place which meant the regional director was able to monitor training levels within the home to ensure staff had completed the training courses they required. Records showed staff training levels were in line with the provider's corporate requirements.
● The provider submitted a training matrix that did not include any training in supporting people living with dementia or supporting people with complex communication needs. After the inspection they told us staff had received the company's required level of training in dementia care..
● Staff told us and records confirmed they received regular supervisions. There were a mix of individual and group supervisions to support staff development.

Supporting people to eat and drink enough to maintain a balanced diet
● People's experience of mealtimes varied and people were not always given the support they needed to eat

and drink. Relatives told us they visited at lunchtime to ensure their family members ate well, as they were not confident they got the right support without their presence.
● Care records did not contain any information about people's dietary preferences. There were dietary preference sheets for recording people's likes and dislikes but, these had been poorly completed. Several people's lunchtime preference was described as "Hot meal." This was not enough information to ensure people are offered choices of food they like.
● People's mealtime experience varied. While some people were offered choices, and were supported to eat in a calm environment, this was not the case for all people, at all mealtimes. For example, on one of the dementia communities people who required a soft diet were not offered any choice. People were all given one flavour of drink then, mid-way through the meal service a drinks trolley arrived and people were then offered a choice. We saw a staff member offer one person a choice between two plates, after they had made their choice, the person sitting next to them was given the other plate without being asked if it was what they wanted. One person told us they would like vegetarian options, but these were not available.
● People and staff told us people made selections from the menu. If they did not want what was on the main menu they could make individual requests for alternatives by 11am. On one residential community a person pointed out that the menu on the tables was the alternative menu, and they had to go to the entrance to the dining room to find out what the main options were.

Staff working with other agencies to provide consistent, effective, timely care
● People and relatives confirmed they were supported to access external support from other agencies where they needed this.
● Records showed the provider made referrals to external agencies for additional support. We saw other agencies visited the home regularly and were there during the inspection. However, the advice and guidance from external professionals was not routinely captured in people's care plans. This meant it was not clear that people were benefiting from this input.
● We noted the provider made referrals for additional support where they had not been able to meet people's needs. For example, we saw a crisis referral had been made for support with one person's behaviour and presentation. However, records showed that these behaviours were well known, and the provider had a copy of a positive behaviour support plan that had been written when the person had been in a previous care setting. The provider had not utilised the information available to them to ensure this person's needs were met.
● We spoke with two external professionals who told us they felt the staff at the home did not always try to find solutions to meeting people's needs before seeking external support. After the inspection the provider told us their Dementia Care Specialist team visited the home on a monthly basis to provide additional support to the home.

Adapting service, design, decoration to meet people's needs
● The home was a purpose built care home however, the provider had recognised that the current arrangement of the home was not suitable for everyone who lived there.
● The registered manager shared their proposed development plans for the service. These included refurbishments for some areas of the home, and dividing the upstairs communities into smaller areas. There were also plans in place to redecorate the home to update the décor which included making improvements to the signage within the home.
● The home was suitable for people with physical disabilities who used mobility aids. The hallways were wide, with plenty of space for people to move. There were mobility aids and grab rails easily available for people.

Supporting people to live healthier lives, access healthcare services and support

● People and relatives told us they were able to access healthcare services when they needed.
● We saw healthcare professionals were visiting the home during the inspection, including the practice nurse and the opticians. People told us the doctor visited regularly and this was confirmed by records.
● Feedback from healthcare professionals was captured in the healthcare professionals log. Care plans contained information about people's healthcare diagnoses, but did not always make it clear what that meant for people. The provider told us people should have specific care plans in relation to their health conditions, but we did not find these in the files we reviewed. For example, one person we reviewed had Parkinson's disease but there was no information within the care plan about what this meant for them, and how it affected their experience of care. There was no care plan in place in relation to Parkinson's disease as described as provider policy. This meant there was a risk that staff did not have clear information about how to support people in relation to their healthcare needs.

Ensuring consent to care and treatment in line with law 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 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.

In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.
● Where people lacked capacity to consent to their care and treatment staff had carried out appropriate assessments to ensure care and treatment was provided in people's best interests in line with the principles of the MCA.
● Relatives told us, and records confirmed, they had been asked to share where they had legal authority to make decisions on behalf of their family member. This ensured only relatives with appropriate legal authority were able to make decisions on behalf of people.
● Where people's care and treatment amounted to a restriction of their liberty, the provider had made appropriate applications to the local authority.

Requires Improvement

# 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 the last inspection this key question was rated as good . At this inspection this key question has now deteriorated to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
● People gave us mixed feedback about how well they were treated, and whether they felt respected.
● Some people told us they found staff very supportive and kind. Some people told us they were supported to attend religious services within the home.
● However, other people told us they found the turnover of staff had a negative impact on their experience. One person explained, "It's never the same staff, some are better than others. Some staff are rather careless, and they swagger around making everyone do things. Although other staff are very good."
● We saw faith representatives visited the home to conduct services for people. However, not everyone who wished to practice their faith felt they were supported to do so. One person said, "The only thing that keeps me going is my faith. I never get to see [faith representative]. If they have services here, I don't know about them." Another person told us they relied on friends to support them to visit their place of worship.
● The assessments used by the service did not explore people's diverse characteristics. People were not asked about their sexual or gender identity which meant they were not assured that the care home provided a safe environment to disclose this information.
● Each care file contained a care plan titled, "Cultural, spiritual and social values." While some of these included details of people's pasts, and family histories, they did not include information about how to support people to maintain links with their cultural background in the home. For example, one person's stated, "Staff to engage [person] in activities to keep [them] company. Talk to [them] so they don't feel isolated, encourage [them] to stay in communal areas during the day." These are not actions that would support someone to feel their personal history was being respected.
● People gave us mixed feedback about how well they were supported to maintain their relationships. Some people told us they felt well supported, and their visitors told us they were always made to feel welcome. However, others told us they felt more could be done to facilitate visits, such as ensuring there were two chairs in people's bedrooms so they could sit together in private.

Supporting people to express their views and be involved in making decisions about their care
● People were not consistently involved in making decisions about their care.
● People told us, and our observations confirmed, that people were not always offered choices and control over their day to day life. Records did not show people, and relatives where appropriate, were always involved in reviewing their care.
● The provider had identified that people and their family members were not always involved in reviews and updates. There was a plan in place to involve people in decisions about their care.

Respecting and promoting people's privacy, dignity and independence

- Staff described the measures they took to ensure people's dignity was promoted and their privacy respected.
- People told us staff were polite and always knocked on their doors and asked permission before providing care and support.
- People told us they tried to maintain their independence. Staff told us they supported people to maintain their skills. However, as care plans lacked detail on how to do this, it was not always clear how people were supported in this way.

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

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 people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● Care plans lacked personalised detail and records of care lacked detail about the nature of support provided to people.
● People and relatives gave us mixed feedback about whether they knew about their care plans and how much involvement they had in writing them. Several people did not know they had a care plan. For example, one person said, "I know I have a care plan but it is not reviewed." A relative told us, "Yes, I know what a care plan is, and I see it from time to time, especially as things change."
● Care plans described people's needs but did not inform staff how to meet them. They did not include details of people's preferences. For example, none of the care plans contained information about the products people liked to use for personal care, or details about people's preferred water temperature. Care plans said people should be supported to wear "appropriate" clothing but there was no information about people's personal style or preferences to ensure people were given support that aligned with their choices.
● Records of care were task focussed and it was not clear that people's presentation was used to inform decision making about their care. For example, one person's continence records contradicted the information provided to the GP which meant it was unclear if the correct medicines were prescribed.
● Records showed care plans were reviewed each month. However, these reviews did not lead to improvements or increases in the level of detail within the care plans.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's care plans were not in a format that was easily accessible to people.
● People's communication needs were described in their care plans. However, there was not enough information to ensure these needs were met. Guidance for staff in each of the communication plans reviewed was generic and stated staff should "reassure" people, or approach them "gently" and "speak slowly and clearly." This was not enough information, particularly for people who had complex communication needs linked to their dementia or other cognitive conditions.
● Other information was not always easily accessible to people. As mentioned in the Effective domain menus were positioned outside dining rooms. One person told us the print was too small for them to read, and there were no pictures of sample plates for people who could not read.

End of life care and support

● As with the main care files, end of life care plans lacked specific details required to ensure people received appropriate, personalised end of life care and support.

● The advanced care plans had been poorly completed and did not include details of the impact of people's cultural background, religious beliefs or family relationships on their end of life wishes. There was no detail about how people wished for their environment to be arranged if they were approaching the last stages of their life. This meant there was a risk that these wishes would not be met, as they were not recorded.

The above issues with the quality of care plans and records, accessibility of information and responses to people's presentation are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medical professionals and relatives had been appropriately involved in making decisions about whether or not people should be resuscitated if their heart stopped beating. This information was clear and prominent within care files.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People gave us very mixed feedback about their experience of the activities and engagement opportunities available at Winchester House. While some people felt engaged, other people told us they were bored and were left to watch TV alone in their bedrooms.

● One person told us, "You are left on your own a lot, if you [member of inspection team] hadn't come to talk to me today, I wouldn't have had anyone to talk to." Another person said, "I occasionally go up to the lounge although not usually much going on."

● Other people told us there had been improvements to the activities provided. One person said, "There have been more activities lately, they've got new ideas which is better."

● There were three activities coordinators working at Winchester House and they told us they were attempting to recruit a fourth. An activities coordinator told us they offered a choice of two activities daily which were based on feedback from people living in the home. The activities included visiting musicians, movement and exercise classes as well as arts and crafts. Small groups were also supported to go on outings outside the home. These had included a Remembrance day service, and a trip to a garden centre.

● Winchester house had built links with two local schools and a playgroup who visited the home regularly. There were reading groups as well as play sessions to encourage intergenerational interactions.

Improving care quality in response to complaints or concerns

● People and relatives told us they knew how to make complaints, however, their experience of the complaints process varied. Some relatives felt their concerns were not addressed.

● Records showed formal complaints were investigated and responded to in line with the provider's policy.

● However, people told us concerns they raised informally, including missing and damaged laundry, details of bedding preferences, and people not always receiving care in timely manner were not always fully addressed despite staff providing assurances that they would be. These issues had not been captured by the provider's complaint system as they had been raised informally.

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 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

- Records showed the management team were completing audits of care files, as well as incident and accident records. These showed they had identified the lack of detail in care plans and lack of personalisation in the records of care. The actions in place were for staff to re-write care plans, however, this had not been effective. Staff had been instructed to re-write care plans since February 2019 but they were still not detailed enough by the time of this inspection in November 2019.
- The provider's quality assurance systems meant a range of management audits were completed on a schedule by the regional director and the quality team. These visits and reports showed they considered the physical environment, feedback from and knowledge of staff, quality of some records and the financial performance of the care home.
- The audit reports showed that issues with the quality of care within the service were well known to the provider and had been known for a significant period. However, the actions had not been completed and this had not been addressed. For example, the documentation audit completed in March 2019 had identified that life stories were missing, and resident of the day was not being completed. The action was that these were to be completed by April 2019 but they had not been done by the point of the inspection in November 2019.
- The regional director quality visits were not effectively identifying or improving issues with the quality and safety of the service. The visit completed in September stated that actions had been completed from previous audits. However, as described above we found these actions had not been appropriately completed as the quality of care plans and risk assessments had not improved.
- The regional director had a dashboard which allowed them to monitor information submitted by the home management team regarding training, incidents, falls, staffing levels and other clinical indicators including pressure wounds. The regional manager told us they sought clarifications and actions from the home management team when the dashboard indicated deteriorations.
- The audits of incidents and falls had not identified that staff had recorded they had updated care plans and risk assessments when they had not done so. The audits of care files had not identified they were missing the care plans relating to specific health conditions as required by the provider's systems. The systems had not identified the dependency assessments were being incorrectly calculated.
- The systems in place were not identifying opportunities for the development of the service and were not applying best practice guidance to the home.

The above issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The provider's values were on display in communal areas of the home.
● The provider's regional audits had identified that staff were not always aware of the company values or processes.
● Staff meeting records focussed on completing records and did not discuss care values. However, supervision records did include discussions around the values base of care.

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 CQC sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The provider understood their responsibilities.
● Relatives told us staff were open and transparent with them and told them about events that took place within the home that involved their family members.

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

● Records showed the provider had identified meetings for people who lived in the service and their relatives had not always been taking in place in line with the company policy. Meetings had been re-introduced to ensure they were giving people and their relatives the opportunity to provide feedback.
● Records showed meetings had been used to discuss activities and the menu. People and their families had been introduced to some of the technology that was available to use throughout the home.
● The provider also completed annual surveys of people and their relatives. We asked for copies of these and were told by different staff that the most recent survey both had, and had not been completed. We were shown the new format which was being introduced following a pilot at other services managed by the company.
● This was reflected in the feedback from people and relatives, who were unsure if they were invited to meetings or asked to complete surveys. One relative said, "There are meetings and surveys occasionally, but it tends to go in fits and starts"

Working in partnership with others

● The regional director worked across a broad geographic area there was an opportunity for services in their portfolio to share learning and experiences. However, we did not see this in practice. Meeting records and action plans did not refer to learning from other services, or working with other services that could have benefitted the people living at Winchester House.
● The activities staff were building partnerships with the local community, including schools and places of worship as described in the Responsive section of this report.
● Following feedback about the provision of dementia specialist support, the regional director committed to the provider's in house dementia specialist team providing additional support to the home to help them develop their skills in this area.

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<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>Needs assessments were not robust and care plans did not reflect people's preferences. Regulation 9(1)(3) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risks had not been appropriately mitigated against. Regulation 12(2) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems and processes had not operated effectively to improve the quality and safety of the service. Regulation 17(1)(2) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>There were not enough staff deployed to meet people's needs. Regulation 18(1) |