Barchester Healthcare Homes Limited

Winchester House

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

The inspection was carried out on 26 and 28 January 2016. Our inspection was unannounced.

Winchester House is a care home for older people. The home is set out in five separate units and comprises the Peter Mews unit which provides care for people with a physical disability; the Marconi suite for people with residential dementia care needs; the LaFarge suite for older people with nursing care needs; and Shorts Terrace and Cathedral Square suites which provide dementia and nursing care. At the time of our inspection 119 people were living at the home, many of whom were living with dementia. Some people had sensory impairments and some people had limited mobility, a number of people were cared for in bed.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

People and their relatives were complimentary about the care and support provided by the service.

Medicines administered were not adequately recorded to ensure that people received their medicines in a safe manner.

The home was not clean in all areas. Some rooms had a strong and overpowering smell of stale urine and some mattresses were stained.

Meals and mealtimes did not promote people's wellbeing. People were not always treated with dignity and respect at meal times. Records relating to food and fluid were not concise. We made a recommendation about this.

Decoration of the home did not follow good practice guidelines for supporting people who live with dementia.

Effective systems were not in place to enable the provider to assess, monitor and improve the quality and safety of the service. Audits undertaken had not picked up the concerns about cleaning, infection control, topical medicines and the decoration of the home.

Recruitment policies were in place. Safe recruitment practices had been followed before staff started working at the service.

Staff had received training about protecting people from abuse and showed a good understanding of what their roles and responsibilities were in preventing abuse.

People's safety had been appropriately assessed and monitored. Each person's care plan contained individual risk assessments in which risks to their safety were identified, such as falls, mobility and skin integrity.

There were enough staff on duty to meet people's needs. Staff had undertaken training relevant to their roles and said that they received good levels of hands on support from the management team.

There were procedures in place and guidance was clear in relation to the Mental Capacity Act 2005 (MCA), that included steps that staff should take to comply with legal requirements. Staff had a good understanding of the MCA 2005 to enable them to protect people's rights.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Deprivation of Liberty Safeguards (DoLS) applications had been made to the local authority and had been approved.

People were supported and helped to maintain their health and to access health services when they needed them.

Relatives told us that they were able to visit their family members at any reasonable time, they were always made to feel welcome and there was always a nice atmosphere within the home.

People's view and experiences were sought during meetings. Relatives were also encouraged to feedback during meetings.

People were encouraged to take part in activities that they enjoyed. People were supported to be as independent as possible.

People and their relatives knew who to talk to if they were unhappy about the service.

Relatives and staff told us that the home was well run. Staff were positive about the support they received from the senior managers within the organisation. They felt they could raise concerns and they would be listened to.

Communication between staff within the home was good. They were made aware of significant events and any changes in people's behaviour.

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

Summary of findings

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 consistently safe.

People's topical medicines were not well managed and recorded.

Effective recruitment procedures were not always in place.

Some areas of the home were not clean and processes to minimise the risk of infection were not robust.

Risks to people's safety and welfare were managed to make sure they were protected from harm.

Staff had a good knowledge and understanding on how to keep people safe from abuse. There were enough staff deployed in the home to meet people's needs.

Is the service effective?

Requires improvement 

The service was not consistently effective.

People had a choice of food and were complimentary about the food, some people had not been treated with dignity and respect at meal times. Records relating to food and fluids were not always accurate.

The decoration of the home did not follow good practice guidelines for supporting people who live with dementia.

Staff had the essential and specific training and updates they needed. Staff received supervision and said they were supported in their role.

Staff were aware of the Mental Capacity Act 2005. Where people's freedom was restricted Deprivation of Liberties Safeguards were in place.

People received medical assistance from healthcare professionals when they needed it.

Is the service caring?

Good 

The service was caring.

People told us they found the staff caring, friendly and helpful and they liked living at Winchester House.

People and their relatives had been involved in planning and had consented to their own care.

Staff were careful to protect people's privacy and dignity and people told us they were treated with dignity and respect. People's information was treated confidentially. Personal records were stored securely.

Summary of findings

Is the service responsive?

Good 

The service was responsive.

Care was offered to people in response to their care needs which had been planned with their involvement. Relatives told us that they were kept well informed by the home.

People were engaged with a variety of activities of their choosing.

People and their relatives had been asked for their views and these had been responded to.

People had been given adequate information on how to make a complaint.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

The registered manager and provider carried out regular checks on the quality of the service. Audits had not picked up the concerns we found during the inspection.

Staff, relatives and health and social care professionals had confidence in how the home was run. Staff told us they were well supported by the management team.

People were encouraged to give their views and feedback about the service. The provider had made changes as a result of feedback received.

Winchester House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 26 and 28 January 2016 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor who was a nurse with expertise in pressure area care, a specialist advisor who was a nurse with expertise in palliative care and an expert by experience. An expert by experience is a person who has personal experience of using similar services or caring for older family members.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed previous inspection reports and notifications before the inspection. A notification is information about important events which the home is required to send us by law.

We spent time speaking with nine people. A high number of people were not able to verbally express their experiences of living in the home. 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 observed staff interactions with people and observed care and support in communal areas. We spoke with nine relatives. We spoke with 17 staff including the cook, the deputy manager and registered manager. We also spoke with the regional operations director.

We received feedback from two health and social care professionals to obtain feedback about their experience of the service.

We looked at records held by the provider and care records held in the home. These included 20 people's care records, risk assessments, four weeks of staff rotas, 10 staff recruitment records, meeting minutes, policies and procedures, satisfaction surveys and other management records.

We asked the deputy manager to send additional information after the inspection visit, including some quality assurance records and audits. The information we requested was sent to us by administration staff in a timely manner.

We last inspected the service on the 16 July 2014 and there were no concerns.

Requires improvement

Is the service safe?

Our findings

People told us that there were enough staff to meet their needs. People told us they felt safe and they were happy with the cleanliness of the home. Comments included, "I am satisfied with the cleanliness"; "Yes I feel safe"; "I feel confident with the staff, kind, caring, helpful"; "Nothing to worry about"; "There are enough staff around" and "Staff are helpful, always there if you need them"

Feedback we received from relatives was mixed. Some relatives told us the home was clean and well maintained. Relatives said that their family members were safe. Some relatives felt that staffing numbers could be improved. One relative said, "Bed linen is poor quality, worn and with holes. It is not very clean. I had to ask for the bed throw to be washed as smelt of stale urine, the staff only agreed when I insisted they smell the throw. It is not a clean comfortable bed to sleep in". Another relative told us, "Staffing is a bit of a concern. Thin on the ground sometimes of an afternoon, staff so busy, no tea trolley". Other comments included, "Home is clean and well maintained"; "I feel my Dad is safe, got no worries"; "She is safe here, it is a weight off our shoulders"; "No cause for concern, absolutely safe"; "I think there is enough staff on duty, always someone here paying attention"

Cleaning standards in the home were generally good within communal areas, such as lounges, dining areas and hallways. However, not all areas of the home were clean. There was a strong smell of stale urine in three people's bedrooms. We checked the inside of the mattresses in these rooms and found that the inside of the mattress were stained and smelly. We reported these concerns to the deputy manager on the first day of our inspection. The deputy manager ordered new mattresses; these were delivered and fitted on the second day of inspection. Some bathrooms were dirty. Toilet seats in a number of bathrooms were stained and cracked. Some pedal bins within bathrooms and toilets were broken which meant that people had to touch the bin lid to open the bin which increased the risk of contamination. Several toilet seats could not be cleaned effectively because the seats were cracked. We reported these concerns to the deputy manager on the first day of our inspection. These toilet seats were replaced. Clinical waste within several sluice rooms was not stored effectively. The clinical waste bins did not have lids, therefore the rooms smelt strongly of stale urine and faeces.

This failure to clean and maintain the premises was a breach of Regulation 15 (1) (a) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed trained staff and nurses administering people's medicines. The trained staff and the nurses checked each person's medication administration record (MAR) prior to administering their medicines. The MAR is an individual record of which medicines are prescribed for the person, when they must be given, what the dose is, and any special information. People were asked if they were in pain and whether they required PRN (as and when required) medicines. Medicines were given safely. The trained staff and the nurses discreetly observed people taking their medicines to ensure that they had taken them. However, medicines records for people who were prescribed creams and other topical solutions were not accurate and complete. For example, the topical medicines records seen detailed that people did not always get their topical medicines as they had been prescribed. The medicines trolleys for two units were left unattended and unlocked for short periods of time during the inspection. This increased the risk of people being able to access prescribed medicines which may cause them harm.

The examples above showed that medicines had not been properly managed. This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were securely stored. The medicines storage areas were clean, tidy and well ordered. Temperatures of all medicines storage was checked and recorded daily, and these records were up to date. Actions identified during an external pharmacy audit in August 2015 had been completed in a timely manner.

Recruitment practices were mostly safe. The registered manager told us that robust recruitment procedures were followed to make sure only suitable staff were employed. All staff were vetted before they started work at the service through the Disclosure and Barring Service (DBS) and records were kept of these checks in staff files. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people

Requires improvement

Is the service safe?

who use care and support services. Nursing staff registration with the Nursing and Midwifery Council (NMC) had been checked and monitored to ensure that only registered nurses were employed. Staff employment files showed that references had been checked. One out of ten application forms did not show a full employment history. This staff member had a gap of four years. Interview records did not evidence that these had been investigated by the provider. We spoke with the registered manager about this who confirmed they had discussed the reason at interview with the staff member and explained to us what this was. The registered manager had not recorded the discussion in error.

Staff we spoke with understood the various types of abuse to look out for to make sure people were protected from harm. They knew who to report any concerns to and had access to the whistleblowing policy. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. The registered manager knew how to report any safeguarding concerns. The registered manager met with the local authorities safeguarding coordinator and other health and social care professionals on a regular basis to review safeguarding concerns to monitor and review the action taken.

There were enough staff deployed on shift to keep people safe. The service used agency staff to cover shortfalls when staff were on leave and off sick. The home used a DICE tool which was a dependency rating tool to assess the level of staffing required for each area of the home. The registered manager explained how they adjusted the staffing levels to meet people's needs. They were able to answer queries relating to the tool and explain that the tool didn't have the intelligence to show exceptions (such as people being in hospital and people receiving one to one support). The registered manager also explained that the home's trainer provided care and support during peak times when they were not providing training to staff and the activities staff provided help at lunch times. We saw that this happened at meal times during the inspection. The DICE tool showed us that there were lower staff numbers than expected in two areas of the home. The registered manager told us that they were recruiting staff to fill vacancies. We observed that staff responded quickly to people's call bells. A health and social care professional said, "The home have a dependency tool for their staffing ratio and good management presence whenever we visit. This appears sufficient whenever I have been and I have had not had concerns raised to the contrary"

Risk assessments had been undertaken to ensure that people received safe and appropriate care. Risk assessments included a list of assessed risks and care needs, they detailed each person's abilities and current care needs. Risk assessments corresponded with each section of the care plan. For example, one person was at risk of falling from their bed as they frequently tried to get out of bed. They had been assessed as being at high risk of falls. The person's bed had been lowered to the lowest possible setting and a pressure mat was situated next to the bed so that staff would be alerted if the person had moved from the bed. Checks were carried out frequently by staff when the person spent time in their bedroom who documented that the person was safe. Risk assessments and care plans had been reviewed monthly or more frequently if people's circumstances changed. Staff were able to provide care which was safe and met each person's needs. Accidents and incidents had been appropriately reported by staff. Relevant action had been taken by the registered manager when these had occurred.

The premises were generally well maintained and suitable for people's needs. Fire extinguishers were maintained regularly. Fire alarm tests had been carried out. Staff confirmed that these were done weekly. Records showed that emergency lighting had also been tested regularly. Any repairs required were generally completed quickly. For example, we found that a piece of handrail had been damaged; the deputy manager reported this to the handyperson who fixed this before we left. We observed that the areas of the home which had been assessed as unsafe for people to enter without support, such as the laundry room, kitchen, sluice rooms and cleaning stores and stairwells were locked and secure. Gas and electric installations had been checked. Hoists and slings had been serviced.

Requires improvement

Is the service effective?

Our findings

People told us that the food was nice and that their healthcare needs were well met. Comments included, "Staff are very helpful, do what they can"; "Staff look after me well, can't fault them"; "I like the food, get enough, always plenty more if I ask. I have a choice and enough to drink"; "Food is very nice, I get a choice and enough to eat. Plenty of drinks"; "Food is very good, no reason to be fussy about the food"; "I get help with hospital appointments"; "I am not on any medication now, but staff help me if I am in pain" and "I feel confident staff would help me if I was in pain".

Relatives told us they had been involved with planning and decisions. Comments included, "I find the staff are very helpful, always there if I have any questions. Nothing is too much trouble"; "Staff are very friendly and helpful"; "Mum is getting help with her personal care. She is thriving here"; "He [family member] gets a very healthy diet, gets enough to eat and he likes the food. Does need more encouragement to drink enough"; "We have been involved in assessment and in care planning. Today had a review which was detailed and helpful. We are involved in decision making and have Power of Attorney in place" and "I have Power of Attorney and I am involved in decision making, waiting for assessment for permanent place".

We received positive feedback from health and social care professionals. One professional told us, "It has been my experience that patients do receive effective and safe care and the staff have always acted on any advice given in a timely manner" and "Changing needs have been dealt with promptly and to a high standard. I have always received excellent communication with both nursing staff and management".

People living with dementia were disorientated in the environment. During the inspection we observed people entering other people's rooms. We alerted the staff who escorted the people to their correct room. Staff told us that one person in one area of the home frequently went to other people's rooms to remove drinks, tidy the person's wardrobes and personal items. Staff explained they monitored this person closely and distracted the person when necessary, care plans and risk assessments detailed these behaviours, staff knew to monitor this person regularly and provide regular checks on people in their rooms to replace drinks. Although people in each unit of the home were living with dementia, the bathroom and toilet doors on the top floor were the only ones with dementia friendly decoration, we noted that people's ensuite facilities in their rooms was not decorated in this way and were not signposted. The registered manager informed us that the ensuite doors would be decorated in a dementia friendly way. One person had been confused and had been urinating in their wardrobe which had left it stained and smelly. People's bedroom doors were mainly painted white with a small name plate high on the door. When we last inspected, there were memory boxes on most doors which contained pictures and items to help people recognise which was their room. These had been removed; which may of made it difficult for people to recognise their rooms. The registered manager explained that the provider was in the process of agreeing a new environmental standard of decoration.

This was a breach of Regulation 15 (1)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Mealtimes were mixed experiences for people. Some dining areas were relaxed and calm with general chatter, with music playing. Some dining areas were cramped and busy. One person in the LaFarge unit who used a wheelchair had to move tables. This was because they needed assistance with eating and there wasn't enough room for the member of staff to sit with them at the table they were originally seated at. The dining area within the Peter Mews unit was only used by two people; the rest of the people received their meals in their rooms. There was little interaction in this dining room at meal times.

We observed one person in the Cathedral Square unit eating independently. We heard a staff member ask another staff member to see if the person needed assistance. The staff member walked over to the person and took the brakes off their wheelchair and moved them backwards without talking to the person. Another staff member reminded the staff member that they needed assistance to be moved anywhere. The staff member then took the knife and fork out of the person's hands without checking if they needed help and began to feed them with a spoon. Another member of staff was observed walking up behind one person who was eating and supported the person to leave. The person asked where they were going and the staff member explained that they were taking the person to the toilet. The person was still chewing their food

and had had over half of their meal left on the plate. When the staff member assisted the person to return to the dining room their meal had gone. The person was given another meal. We spoke with the registered manager about this. The registered manager investigated and told us that the person had been asking the nurse on duty to go to the toilet. The nurse had passed this on to a member of care staff, who then arrived in response to the request. By this time the person had forgotten they needed to use the toilet and was engaged in eating their meal. There were some delays to some people receiving their meals, we observed one dining area running out of knives and another dining area running out of plates.

These examples evidence that people had not been treated with dignity and respect at mealtimes. This was a breach of Regulation 10 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records of meals eaten were not always robust and clear. We checked the meal request sheets and found gaps where it had not recorded what people had chosen to eat. We visited one person in their room to check that they had food, they did have food in front of them but they didn't like what had been given so hadn't eaten it. The deputy manager arranged for this person to have something else to meet their needs.

We recommend that the provider ensures records are clear, concise and robust to evidence care and support given.

There was plenty of food in stock. This included fresh fruit and vegetables, meat, tinned food, dried food, frozen and dairy foods. The chef had a good understanding of people's dietary requirements because they had a log which recorded people's like and dislikes, the texture of food such as finger food, soft meal and pureed. Nutritional needs and food likes and dislikes had been recorded within people's care files. The chef had a good understanding of how to fortify foods for people who were at risk of malnutrition.

Menus were on display in each dining area. Menus evidenced that people had a good choice of food during each meal of the day. We observed staff plating up meals at each meal time to show people what the food looked like which helped them to choose what they liked. We also observed staff pouring different drinks and showing people these to help them choose. Drinks were provided at meal times and on demand. There was also a tea trolley round in the afternoon which included fresh fruit. We observed meal times in each unit of the home. The food smelt good and was nicely presented, there was little wastage on the plates. People's individual requests were responded to. For example, the kitchen made some gravy specifically at the request of one person and another person had a little piece of all three pudding options. People were encouraged to drink fluids throughout the day. Staff were seen taking fresh jugs of drinks to people who received care and support in bed. Staff mostly interacted in a positive and cheerful way with residents throughout the meal time.

Staff had received training and guidance relevant to their roles. Training records evidenced that all staff had attended fire, infection control and safeguarding adults training. Records showed that 105 out of 107 staff had attended Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS) training. Care staff told us that they had been provided with guidance and instructions relating to administering prescribed creams and lotions, this training had been provided by the home trainer. All staff had completed dementia awareness training. One staff member of housekeeping staff explained, "Everyone does dementia training. It's very important as they have contact with the residents". Nursing staff told us that they had attended courses in relation to nursing practice and skills such as customer care training, Phlebotomy, and male and female catheterisation. Care staff were encouraged to undertake health and social care qualifications.

Staff told us they had good support from the management team. Staff had received supervision from their line manager. Nursing staff supervised care staff and the registered manager and deputy manager supervised the nursing staff and housekeeping, kitchen and maintenance staff. Nursing staff were supported and supervised by the deputy manager, who also provided clinical supervision. This meant all staff received effective support and supervision for them to carry out their roles.

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.

Requires improvement

Is the service effective?

People had DNAR's (Do not attempt resuscitation) records in place that had been completed with the GP. Records evidenced that families had been involved in the decision making process about this. However, one person's records evidenced that the person's relatives had not been involved at the time of the decision and when the decision to not resuscitate their family member had been communicated to them they had not agreed. The registered manager advised that the person moved into the home with a DNAR in place and that they would arrange for the GP to have a discussion with the relatives to discuss further.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager and staff we spoke with had a clear understanding of the MCA and DoLS. One member of staff told us that they would, "Assume capacity" and explained that they helped people to make decisions. One member of staff understood that people could make unwise decisions. Staff understood that where people lacked capacity best interests meetings and decisions should be made involving the person and their family. Appropriate applications and authorisations to deprive people of their liberty had been made. The registered manager had clear systems in place to track and monitor DoLS applications and authorisations.

People received medical assistance from healthcare professionals when they needed it. Staff recognised when people were not acting in their usual manner, which could evidence that they were in pain. Pain assessments had been carried out and evidence showed that people had received pain relief when it was required. Staff had sought medical advice from the GP when required. Referrals had been made to speech and language therapist (SALT) and tissue viability nursing service (TVN) for people who needed it. Records demonstrated that staff had contacted the GP, ambulance service, dementia specialists, physiotherapists, hospital and relatives when necessary. People who were at the end of their life received support from the palliative care team in setting up anticipatory medication. We observed a telephone call from the palliative care nurse to the ward nurse with further advice from a geriatrician and the arrangement of a pharmacist visit to advise on medication. This also involved the GP and was a good example of multidisciplinary team work. Specialist nurses were involved in relation to Parkinson's disease and diabetes. People had seen an optician on a regular basis to check the health of their eyes. Where people had pressure areas, appropriate action had been taken. Photographs had been taken at each stage so that there was a clear record of the wound and how it was progressing. Suitable systems were in place to monitor people's health.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. Comments included, “Staff are helpful, always there if you need them”; “I feel very comfortable with the personal help I get, they do what is needed”; “They always knock on the door, even when it is open, they are respectful”; “Confident with the staff, kind, caring, helpful”; “I can choose to just have female help”; “Staff are pleasant”; “Staff are kind and very caring. They do not hurt me and know my likes and dislikes”; “Staff listen to me and help me” and “Staff know me well, know my likes and dislikes”. We observed that staff were friendly and helpful. We saw positive interaction with people, showing good communication skills.

Relatives told us that their family members were treated with kindness, dignity and respect. Comments included, “Staff show exceptional communication, kind, caring and warm. No hint of anything else”; “They listen to her, show respect and encourage her” and “The staff talk in a caring way, help her to move and offering drinks”. A health and social care professional told us, “The staff appear to be kind and gentle in their approach with clients”.

During the inspection we observed staff knocking on doors and asking permission to enter. Staff crouched down to ensure they were at the same level as the person when talking with them. People being cared for in bed were approached gently by staff, staff explained who they were and offered gentle prompts to encourage interaction. Staff described how they maintained people’s privacy whilst supporting them with their personal care needs, such as ensuring that doors were closed, people were covered up and curtains were closed. A nurse told us that they treated people with dignity by respecting their wishes, talking to them as an individual and listening to them and helping them to express themselves.

People were free to move around the home. When staff passed people in the corridors we saw them stop and chat. People living on the Cathedral Square unit could actively walk in loops around the whole unit without having to turn around or get to a dead end. Staff interacted with people when they passed by and encouraged them to stop, have a rest, join an activity, have a chat or have something to eat. Staff also joined people on their walks. We observed that the gardens were secure and contained a number of seating areas to enable people to use the grounds when the weather was nice. No one used the gardens when we inspected as it was cold and wet.

Interactions between staff and people who lived at the home were positive and caring. Staff were kind, caring and patient in their approach and had a good rapport with people. Staff supported people in a calm and relaxed manner. They did not rush and stopped to chat with people, listening, answering questions and showing interest in what they were saying. We observed staff initiating conversations with people in a friendly, sociable manner and not just in relation to what they had to do for them.

Most people’s rooms had been personalised with their own belongings. Some rooms were sparse and contained very little furnishings. We spoke with staff about this and they told us that this was because those people had broken and damaged all of the items in their room; therefore the contents of their rooms were kept at a minimum to prevent injury.

People told us that they were asked how they want to be cared for and about their likes and dislikes. Care plans were detailed and clear. They included information about people’s life such as previous occupation, family and friends and important dates and places. This meant that staff had information to help them communicate and interact with people.

Relatives told us that they were able to visit their family members at any reasonable time and they were always made to feel welcome. One relative explained they visited weekly and other members of family also visited. They said, “I’ve been impressed with care all the time, never alters, it’s always the same” and “Staff are flexible and really know her”. People had access to pay phones which were located in quiet areas in the corridors of each unit, this enabled them to speak privately to their family and friends if they wished.

Staff had a good understanding of the need to maintain confidentiality. People’s information was treated confidentially. Personal records were stored securely. People’s individual care records were stored in the nurses

Good

Is the service caring?

stations on each of the units to make sure they were accessible to staff. Staff files and other records were securely locked in cabinets within the offices to ensure that they were only accessible to those authorised to view them.

People's religious needs were met. The activities schedules showed that church services and church coffee mornings took place. Activities staff told us that a religious leader visited the home on a monthly basis to give communion.

Good

Is the service responsive?

Our findings

People told us they knew who to complain to if they were concerned. Comments included, "I haven't got anything to complain about"; "If I had a complaint I would ask to see the manager" and "I feel able to state my preferences".

Relatives confirmed that they were involved in decision making processes. One relative said they had been asked to complete a survey six months ago. Relatives knew the management team and were confident about who to talk to if they had a concern or complaint. One relative said, "If I had a complaint I would go to the office or see the manager". Relatives told us that staff kept them well informed regarding changes to their family member's health.

We observed activities taking parts in different parts of the home during the inspection. People were involved in activities and others sat watching the activity and had clearly chosen to take part. During one activity where staff were encouraging people to catch and throw a balloon, which encouraged people to be more active, the staff member engaged with people in the room to enable them to take part. One person made it clear they didn't want to have another go. They said no when asked if they wanted to join in and said "It's a bit of a waste of time", but happily sat and watched others. Some of the activities were very lively and people seemed to be enjoying them. People were informed about planned activities as the schedule was sent to people weekly. Staff then walked round to visit people each day to encourage them to take part. One relative explained that their family member was cared for in bed and could not take part in activities, their bedroom door was left open so they could see people and staff go past. They explained that their family member was "Happy on their own".

The activities schedules showed that outside entertainers visited the home to provide activities as well as activities which were coordinated by the two members of activities staff. Music and singing activities were very popular with people. Activities schedules showed that people had access to ball games, dominoes, memories and reminiscence sessions, board games, knitting, coffee mornings and role play. Generally there were two activities planned each morning and two activities planned each afternoon. Activities staff told us that they try and spend one to one time with some people. One staff member said, "We bring in newspapers for people every day and take them to people who want them. We also go into every room every day and say hello to people". We saw records and photographs of a virtual cruise which had taken place in 2015. People choose which countries they would like to visit on their virtual cruise and activities, food and entertainment was based around that. The kitchen staff got involved to create menu's that complemented the activities that were planned around particular countries. Countries included China, India and Italy. People living in all parts of the home took part.

Volunteers also visited the home to spend time with people in their rooms. The local primary school visited the home regularly which engaged children and people in singing, art and sharing sweets.

People were supported to go on trips outside of the home. Trips in 2015 included taking people out to places like a garden centre where people can see the aquariums and animals and into the local town for coffee. People also visited another local home run by the provider to join them for planned activities. The activities staff had joined local forums to get ideas for activities and spoke with us about future plans to get a mobile museum to visit the home.

People's care files contained detailed assessments of their care needs. Assessments had been carried out by nursing staff prior to the person moving to the home. The assessments highlighted areas of need such as communication. One person was blind, another wore glasses another had difficulty understanding information. Continence assessments highlighted where people had a catheter or used continence pads. People and relatives told us they had been involved in the care planning process. People said that they had been given a choice of who could assist them with their personal care. One staff member explained how one person responded better to male staff, the rotas demonstrated that male members of staff were allocated to work on that particular unit to respond to this. Residents and families contributed towards the initial assessment and care reviews. Peoples care assessments evidenced their preferences such as choosing clothes to wear, joining in with activities, male or female staff, whether to have a bath or shower and food choices.

Care files (where appropriate) included an advance care plan that included information about the wishes of the person at the end of their life. Care plans were regularly reviewed and this included input and comments from

Good

Is the service responsive?

relatives. People who were at the end of their life had been assessed and monitored by their GP frequently. Records showed that referrals had been made to the palliative care team at the local hospice and end of life facilitators from Medway Healthcare Trust. Where advice and guidance had been given, care plans had been rewritten and included updated medicines. Spirituality had been discussed in the advanced care planning. One nurse told us about a person who had specific needs after their death, such as a funeral the next day.

All staff were aware of the home's complaints procedure and this was displayed within the lobby of the home. Nursing staff detailed how to respond to complaints, initially listening and dealing with a verbal complaint but advising people that the complaint could be put in writing. People had a copy of the complaints procedure in their rooms. Although generally positive feedback was given about the responses to complaints. One relative told us that they had raised frequent concerns with staff about lost items, clothing and bed linen. They explained that they had stopped raising the concerns as nothing appeared to get resolved and stated, "So long as he is clean and well cared for, we just solve everything else". This may show where verbal complaints had not been escalated to the management team in line with the company policy.

We reviewed the complaints records and saw that written complaints were documented and the records evidenced that they were responded to within agreed timescales. The response included an investigation and when warranted an apology was provided. The person who made the complaint was provided with a clear explanation of the steps that were taken to prevent the issue from being a problem in the future.

The provider carried out an annual survey of people through a market research company. The registered manager explained that the surveys were sent out to people and the responses were collated by the external company, who then produced a report. There were no survey results available to view for the most recent survey.

The home had received 10 recommendations on www.carehome.co.uk within the last 12 months. One positive comment stated, 'I was extremely pleased when my wife was accepted into the Winchester House Care Home. She was admitted for palliative care for end stage dementia. All the staff were outstanding. They showed kindness, compassion and professionalism to my family and myself at every stage from admittance, right up until my wife passed away'. Compliment cards had also been received. One card read, 'I would like to thank the staff for their very hard work and dedication'.

Requires improvement

Is the service well-led?

Our findings

We observed that the deputy manager spent time in the home and knew people well, people knew who the registered manager was.

Relatives told us that the home was well run and they had confidence in the management. Comments included, "One of the better homes"; "Managers are very approachable"; "Home is well run, well managed". Two relatives made comments about frequent staff changes. One relative said, "Come in regular days and get to know staff, then suddenly all change". Another relative said "Staff move around, sometimes come in and do not know anyone". However, staffing rotas showed that there was consistent staff working across the units with the use of agency staff to cover sickness, leave and vacancies.

Health and social care professionals stated, "The service appears to be very well led, with a sound staff structure. I have no concerns about this service" and "The service works really well with us. Understands the need to keep families involved and informed. The manager has a really detailed knowledge of residents despite this being a large home".

The registered manager and provider had audits systems in place. A number of audits were carried out at the home that monitored the quality of the service and identified any areas where improvements were required. An audit from October 2015 evidenced that the registered manager had carried out observations during one meal time and during the virtual cruise. Interaction levels had been noted, these were seen as positive. The audit had highlighted that the mealtime was very busy and some people had their meals in the lounge due to lack of space in the dining room. The regional director also carried out quarterly audits which checked all areas of the home, clear lists of actions had been created and the registered manager had ensured that tasks had been completed. However, audits had not picked up the concerns we found in relation to infection control, cleaning, records relating to topical medicines and people being disorientated in the environment due to lack of dementia friendly signage. This meant that audit systems and processes were not always robust.

The failure to operate effective systems of processes to monitor and improve the quality and safety of services was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and the deputy home manager both carried out unannounced visits to the home during the evenings, weekends and overnight to monitor the operation of the home at these times. Information about these unannounced visits was documented to show any observations and confirm that the home was being run as it should at these times.

Audits were carried out that monitored areas such as the provision of training for staff and access to supervision and appraisal. Infection control and health and safety audits were also carried out at the home to make sure people were safe. An external pharmacy audit had been completed in August 2015 and actions recommended had been taken. External contractors checked equipment such as lifts, hoists, slings and gas fittings.

Weekly bulletins were sent to home managers from the organisation to make them aware of pertinent and important information. This included information about medical devices alerts and changes to regulations. Staff received information and news about other homes and services within the provider's organisation through a staff newsletter. This gave staff an opportunity to get involved in different projects as well as providing career development within the organisation.

The registered manager had a good understanding of their role and responsibilities in relation to notifying CQC about important events such as injuries, Deprivation of Liberty Safeguards (DoLS) authorisations, safeguarding, any deaths and if they were absent from their role. The registered manager explained that they had good support from their manager and the provider. They received supervision meetings, monthly managers meetings, which enabled them to link up with other registered managers in the organisation to gain and provide peer support. The local authorities safeguarding coordinator also told us that they received timely reports of incidents and events and that there was "Good open communication and prompt responses to requests for information".

Staff told us they felt well supported by the management team. The nurses said they were listened to by management and that there was good communication.

Requires improvement

Is the service well-led?

Care staff explained how they were supported by the nurses. One member of care staff said, "Communication is good" they went on to say that if mistakes happen there was a culture of learning, the issue would be discussed and items would be shared at handover meetings to ensure relevant people knew what had happened.

The registered manager felt well supported by the provider and by the regional director. The registered manager linked up with other registered managers within the local area for regular meetings and felt well informed about the provider's national objectives.

One staff member said, "Barchester is a good company, they offer developmental progress, can do things other than caring. They explained care staff could gain a qualification and develop in the company to a care practitioner role, which enabled them to be involved in administering medicines and assisting nursing staff with wound dressings. Another staff member said that the provider's mission was to "Try and give your best to give the best life to residents". The registered manager said they were "Most proud of my staff and the care they give". We observed that staff provided good care to people during our inspection.

The registered manager explained that the home regularly accept admissions for people who can display challenging behaviour towards others. The registered manager spoke warmly about watching people settle in to living at the home, "It's lovely to see". A health and social care professional said that "This is a very large provider and they take lots of CHC [continuing health care] funded people with behaviours that other homes haven't been able to or can't manage, so we do understand this is a challenge". They went on to say, "Staff are very responsive and actions are always taken once the risk known".

Policies and procedures were in place to support the staff to carry out their roles effectively. Records completed by staff were clear and concise. These had been completed thoroughly, without gaps. This meant that people's care records contained up to date and relevant information about their care.

Meetings were held on a daily basis to discuss the running of the home. These included members of maintenance team, housekeeping team and the catering team. Discussions were documented to show what actions had been agreed at the meetings. Monthly clinical meetings were held with nursing staff to focus on areas such as wound management, falls management, nutrition and to discuss items which were key to remaining registered as a nurse such as revalidation.

Regular meetings were held with people. Relatives were encouraged to join these meetings. Records showed that a few relatives had attended one out of four meetings held. Suggestions and ideas were taken and acted on where possible. For example, during one meeting people had raised they would like to attend mass at a catholic church once a month. At the next meeting the records reflected that one trip to the catholic church had taken place, although this hadn't happened monthly.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People who use services and others were not always treated with dignity and respect.** Regulation 10 (1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Topical medicines had not always been managed effectively.** Regulation 12 (1)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The provider had not ensured that the premises were effectively cleaned and maintained and that they were suitably decorated to meet people's needs.** Regulation 15 (1) (a)(c)(d)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had failed to operate effective systems of processes to monitor and improve the quality and safety of services.** Regulation 17 (1) (2) (a) (b) (c)