Wirral Christian Centre Trust Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service:
Wirral Christian Centre is a 'care home' otherwise known as Orton House. Orton House is registered to provide accommodation for up to 39 older people. At the time of our inspection, there were 25 people living in the service.

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

At this inspection, we identified concerns with the management of risk, care planning, the delivery of care, medicines, infection control, record keeping and leadership and governance. Audits and checks were not always completed by the registered manager and provider. Those completed were not always effective at making improvements where actions were required. This posed potential risks within the service.

Staff did not always have sufficient or accurate information about people's needs and lacked guidance on how to provide safe and appropriate care. Medication management was unsafe and placed people at risk of avoidable harm.

The service was clean, and staff used appropriate techniques to prevent the spread of infection. However, aspects of managing infection control lacked appropriate oversight to ensure the service had safe systems. The isolation procedures were not followed appropriately, staff had not all competed required training and oversight of the testing programme was not effectively taking place.

People told us they liked living at the service, but some relatives felt they needed more access to social support and activities.

Record keeping supporting people's needs were not always documented and up to date within care records. Some people's clinical needs were not properly monitored to keep them safe and where professional advice had been given; this had not always been followed.

Accident and incidents and safeguarding events were recorded. However, some of these incidents had not been acted on appropriately.

The systems in place to monitor quality and safety were ineffective. Although new systems had been implemented, they were not reflecting the actions to improve the service provision and lacked oversight.

This is the second time, since 2020 that the service has been rated inadequate. It was clear that both the provider and registered manager lacked an understanding of regulatory requirements and how to ensure people received safe and appropriate care. This placed people at significant risk of avoidable harm.

There were enough staff on duty to support people. Staff were observed to be kind and caring and people

told us they felt safe. People and relatives we spoke with were positive about the service however comments were made that there could be more staff.

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

The last rating for this service was inadequate (published 15 January 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found no improvements in breaches for regulation 12 and 17. Improvements had been made and the provider was no longer in breach of regulation 18.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We undertook this targeted inspection to check whether the Warning Notice we previously served in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. Also, a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also looked at management of staffing levels and staff training. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for the service has not changed following this targeted inspection and remains inadequate.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have identified continuing breaches in relation to safe care and treatment and good governance.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Wirral Christian Centre Trust Limited

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.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was undertaken by two inspectors, a specialist advisor pharmacist, and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Service and service type
Wirral Christian Centre Trust Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service and two relatives about their experience of the care provided. We spoke with six members of staff including the registered manager, senior care workers, care workers, a domestic and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
Due to the impact of the COVID-19 pandemic we limited the time we spent on site. Therefore, we requested records and documentation to be sent to us and reviewed these following the inspection visit. We contacted people using the service and their relatives by telephone to seek feedback about their experiences of the care provided. We continued to seek clarification from the provider to validate evidence. We also liaised with the Local Authority to share information about the service and our inspection. We concluded the inspection on 22 June 2021.

Inadequate

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 inadequate. At this inspection this key question has remained the same.

At our last inspection, the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Staff did not have adequate information or guidance about people's needs, risks or the care they required in order to ensure their health and safety was maintained. This placed people at significant risk of receiving inappropriate and unsafe care.
- People's care was not properly monitored to ensure their needs were met. Records did not clearly show if people had received the care they needed to keep them safe and well.
- Professional advice in respect of people's risks was not always adhered to. For example, one person with high risks in their outcomes for pressure areas requiring monitoring had no care plan assessments completed for two months. There was no moving and handling risk assessment in place to inform staff of what support was required.
- Accidents and incidents were recorded, and we saw that not all appropriate action had been taken to seek medical attention when required.
- Environmental risk assessments were not always completed to show what actions had been taken to address areas of risk and repair. For example, two windows were in need of repair. One person's bedroom window had no restrictor, and a window was broken above a fire exit. The provider acted on the information shared and repaired the bedroom window and initiated the work on the broken window above the fire exit that required scaffold being erected to complete the work.

The provider had not ensured people's risks were adequately assessed, monitored and managed to prevent avoidable harm. This was a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

●The quantity of liquid medication in the home was not effectively recorded so it was impossible to determine if people had received the prescribed medication they needed.
● Medication allergies were not always accurately recorded. This placed people at risk of being given a medication they were allergic to.
● People were at risk of receiving some doses of their medication too close together or, at the wrong times because there were ineffective systems in place to ensure timeframes were adhered to.
●The guidance for staff to follow when administering 'when required' medicines such as painkillers or creams was not sufficiently detailed to ensure these were administered safely.
● Information on the administration of diabetic medication was missing, which meant it was difficult to tell if people's diabetes was managed properly.
● Medicines were not always stored safely or at the right temperature. Records detailing the temperature at which medicines were stored were not clear or consistently completed.
●Waste and unwanted medicines were not stored safely in line with current guidance.

The management of medication was unsafe. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had personal emergency evacuation plans in place to advise staff and emergency personnel how to evacuate them safely in the event of a fire or other emergency. The emergency grab bag was seen; however, it should be stored in the fire safety locker in the reception.

Systems and processes to safeguard people from the risk of abuse
● The registered manager logged and reported safeguarding incidents to the Local Authority and CQC in accordance with the regulations. However, we saw accident and incident records that required reporting.
● Staff were clear on the potential signs of abuse and how to raise any concerns they might have. Training on safeguarding vulnerable adults was now being provided however there were staff who had not completed.
● People and their relatives told us they felt safe at the service.

Staffing and recruitment
● On the day we visited, there were enough staff on duty to meet people's needs.
● Staff recruitment files had improved with management oversight.
● Staff training records were in place however not all staff had attended training covering risks in infection control and health and safety, Control of Substances Hazardous to Health (COSHH).
● The registered manager confirmed additional recruitment had taken place, including domestic staff for weekends.

Preventing and controlling infection
● Appropriate infection prevention control policies and procedures (IPC) in respect of COVID-19 were not in place.
● We were not assured that the provider was accessing testing for the staff, records did not always reflect that testing had been completed in line with government guidance.
● Personal Protective Equipment was in use but not always worn appropriately. Clinical waste bins for the

donning and doffing of PPE were not available in some parts of the home. There were also lids missing from a number of clinical waste bins which created a risk of cross-contamination.
● There was a lack of management and safe oversight of training staff with infection control. This was a concern at the last inspection.

The provider had failed to follow government guidelines on infection prevention and control putting people at risk of infection. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Inadequate

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.

The purpose of this inspection was to check if the provider had met the warning notice we previously served. At the last inspection, this key question was rated as inadequate. At this inspection, this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- There were audits in place and new systems implemented by the registered manager. However, when we looked at the audits, they had not been effective in identifying the shortfalls found at this inspection. Medication audits failed to identify the serious concerns we found at this inspection. Assessment reviews for identified risks had not been completed.
- The service had ineffective oversight of managing quality and risks within the service.
- People were at risk of not receiving appropriate care and treatment. People's medication and care needs were not documented appropriately to evidence safe management of their care.
- Management of infection control required improving to ensure risks were limited and to ensure staff were fully trained in all aspects of infection control including arrangements for COVID-19.

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 registered manager had reported notifiable safeguarding incidents to CQC as required. However, accident and incidents had not always been reported. For example, one person who is a diabetic required hospital treatment records were sparce with no timelines or explanations.

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

- Feedback had been sought from people living in the home, through surveys and meetings. The provider told us surveys had also been sent to relatives, but not all relatives we spoke with were aware of this.
- People told us they were happy, some relative's felt that access to activities could be improved. Comments included, "We're very happy, there haven't been any requests for feedback or questionnaires from the registered manager" and "We talk to the staff over the phone.".

Continuous learning and improving care- Working in partnership with others

- Some people received support from other health and social care professionals such as the district nurse teams, local GP and mental health services, as required. However, professional advice was not always acted upon.
- Training records for staff were looked at and the provider sent the training matrix for all staff. However, we found that not all staff had completed infection control training.

The governance arrangements in place were not robust, managerial oversight was poor and record keeping was not always adequately maintained. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found no evidence that people had been harmed however, systems we found to monitor the service were either not in place or fully embedded to demonstrate safety and quality was effectively managed. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.