Wilford View Ltd

Wilford View Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Wilford View Care Home is a purpose-built residential care home providing accommodation and personal care for up to 83 people, including people living with dementia over three floors. At the time of the inspection 61 people were living at the service.

People's experience of using this service and what we found
The risks to people's health and wellbeing were not always clearly documented, assessed or managed. People's records were not always detailed or up to date. People were at increased risk of harm because lessons were not always promptly learnt from incidents that occurred at the service.

There was enough staff to meet people's needs. However, staff turnover, including management staff, was high. This prevented people and their relatives from building rapport with the staff. People and their relatives told us the support from the agency staff, "Was not the same," as from the permanent, long standing members of staff. Some people and relatives said the agency staff did not know people well enough to provide good quality, person-centred care.

People were at increased risk of not having their medication administered correctly because their care plans were not always clear. The application of barrier creams to prevent skin from getting sore was often not documented.

People were at increased risk of catching and spreading infections, because staff did not always wear their PPE correctly.

People and their relatives were concerned about the management of the service. They noticed the lack of consistency and opportunities to express their feedback. The service was not led effectively because the systems and processes to monitor the service were not implemented or used efficiently. As a result, the quality of care was negatively impacted upon.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 13 May 2021).

Why we inspected
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.

The inspection was prompted in part due to concerns received about a high level of safeguarding incidents at the service. As a result, we undertook a focused inspection to review the key questions of safe, caring and well-led only.

The information CQC received about the incidents indicated concerns about the management of risks to people's health and wellbeing. This inspection examined those risks.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report.

You can see what action we have asked the provider to take at the end of this full report.

We requested the provider to immediately mitigate the urgent risks identified during the inspection and to provide us with an action plan on how other shortfalls will be addressed. The provider had taken agreed actions to mitigate the risks.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wilford View 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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment and the governance of the service.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Wilford View Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

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
Two inspectors completed a site visit. An Expert by Experience made telephone calls to relatives off site to seek their feedback. 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
Wilford View Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

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 reviewed information we had received about the service from a variety of sources including notifications received from the manager (events which happened in the service that the provider is required to tell us about). We sought feedback from the local authority and professionals who work with the service. We also contacted Healthwatch for feedback about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We observed staff engagement with people and spoke to five people who used the service. We also spoke with six people's relatives. We spoke with the manager and acting deputy home manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with a care co-ordinator, the maintenance person and five care staff.
We reviewed a range of records. This included six people's care records either in full or specific parts and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including audits and checks of the environment, premises and equipment, accidents and incident analysis.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Arrangements to manage risks had not always been effective. Risk assessments did not include guidance for staff on how to manage them. For example, two people with swallowing difficulties had no mitigation plan to reduce and manage those risks. This placed the people at increased risk of choking.
- People who lost a significant amount of weight did not have their diet monitored effectively. The food charts did not always indicate what food and fluids had been offered or did not specify what amount had been consumed. This increased the risk of malnutrition and dehydration.
- Information on how to manage risks to people was not always accurate or up to date and information in people's care plans was inconsistent. For example, the guidance on how often staff should support repositioning people with pressure sores was inconsistent. This increased the risk of skin damage.
- Monitoring charts were not consistently completed which meant we could not be assured that people were receiving the care and support they required. For example, we found that a person's catheter changes were not being completed regularly which put the person at risk of complications.
- Arrangements for reviewing and investigating safety and safeguarding incidents were not always effective. Whilst the incidents were recorded and reported correctly, lessons were not being learnt to prevent them from reoccurring. For example, there was a recent substantiated safeguarding incident involving poor catheter care at the service. However, at the time of our inspection another person with catheter care did not have an appropriate care plan in place. This placed them at risk of harm and lessons learnt from the substantiated safeguarding incident had not been applied.

Using medicines safely

- Some people were prescribed topical medicines to maintain healthy skin. There was no consistent documentation to confirm the creams were applied. This increased the risk of skin damage.
- People's medication care plans were not always clear. For example, one person required their medication to be crushed, however this was not explained in the person's care plan. This increased the risk of the medication being administered incorrectly.

The provider had failed to assess risks and monitor and manage people's safety and medicines adequately. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014. We asked the provider to immediately address the concerns identified during our inspection. The provider responded within an agreed timescale after the inspection. They confirmed all identified risk assessments and care plans had been reviewed and updated. They completed an audit of all topical cream records, reviewed and updated relevant people's medicines care plans.

Systems and processes to safeguard people from the risk of abuse

● People were not always effectively protected from harm. For example, there were recent safeguarding incidents at the service relating to poor pressure sore management, choking and catheter care.

● The manager reported safeguarding concerns to external agencies correctly.

● Staff had received safeguarding training and knew the provider's policy and procedure to report neglect and abuse.

● People and their relatives told us they felt safe at the service. One person said, "It is safe here, they look after me, I like it here."

Staffing and recruitment

● Staffing levels were based on people's assessed dependency needs. Whilst there was enough staff to meet people's basic care needs, there was a high staff turnover and a high reliance on agency staff. This prevented people and their relatives from getting to know the care staff.

● A relative told us "No there isn't enough permanent staff. At the moment there is a big recruitment thing. You recognise three or four, but all the rest are new."

● People told us they mostly did not have to wait long for support from staff. One person told us, "I have a buzzer to alert staff, I don't have to normally wait long to get help."

● Staff raised some concerns about staffing levels and agency use. One staff told us, "It's different every day, we can be quite short staffed with a lot of agency use but we have enough staff to meet people's needs most of the time."

● Staff were recruited safely. Recruitment checks, including Disclosure and Barring Service (DBS) checks were completed before staff commenced to ensure they were suitable to care for people. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

● Staff were not always using PPE effectively and safely. A recent assurance visit from the Local Authority identified not all staff wore their PPE correctly. At the time of our inspection, we found some staff continued to wear PPE incorrectly. This increased the risk of catching and spreading infections.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● Visitors were able to visit Wilford View Care Home in line with the government guidelines.

● Visitors were supported to wear appropriate PPE.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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

- Whilst staff had enough time to meet people's basic care needs, they did not always have the time to sit and talk with people for a meaningful length of time.
- People told us the staff were caring, however they found it difficult to build a rapport with them due to high staff turnover. One person said, "The carers, the regular ones are very good, you get to know them very well. But you get a lot of agency and they don't really talk to you because you don't get to know them."
- A relative told us, "Staff are kind and caring. The permanent staff know [person's name] well. They might be working with someone I don't recognise."
- During the inspection we observed staff engaging with people in a caring and warm manner.

Supporting people to express their views and be involved in making decisions about their care

- People's views and opinions were not always sought and as a result people did not always felt listened to.
- One person told us, "The biggest thing is we used to have meetings every Monday and since [the last manager] left we only had one [meeting]. That means you do not get a say." Another person said "We used to have meetings but not anymore. I miss it."
- During the inspection we observed people being given day to day choices such as what they wanted to eat and where they wanted to spend their time.

Respecting and promoting people's privacy, dignity and independence

- People's privacy was not always maintained. On the day of inspection, we found personal information for one person had been left out in a communal area which meant that it was not protected against improper access or loss.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There was no register manager in the service. People and their relatives had concerns about the inconsistent leadership in the service. One person told us, "I've never met the manager, she's only been there a short time. There have been three or four managers since last January. Over and above the manager, the home is presumably owned by someone but there is no contact from them."
- Support for staff from mangers was inconsistent. Staff told us they were stressed due to frequent management changes. One staff said, "I find it difficult with all the new managers." Another one said, "It is hard at the moment, I'm stressed with the management changes."
- The service was not led effectively. Quality assurance systems and processes to monitor the service were not implemented or used efficiently. For example, audits were either overdue or not effective in identifying shortfalls found during our inspection.
- The systems to identify risks to people's health and safety were not effective because they did not provide staff with guidance on how to mitigate risks to people. As a result, people were at increased risk of harm.
- Actions to introduce improvements were reactive. Learning from incidents was not applied consistently. As a result, people were at risk of incidents reoccurring.
- For example, there was an incident of poor catheter care leading to a person being hospitalised. Despite this, during our inspection we found that other people who received catheter care had no guidance for staff to follow on how to support with this need.

The systems and processes used to monitor the quality and safety of the service were ineffective. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the provider appointed a new, experienced manager to lead on the governance of the service. The provider and the new manger completed relevant quality assurance checks and started to work on reducing the shortfalls identified during our inspection.

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

- The culture of the service was not always open and transparent. Staff were not always promptly informed about outcomes of safeguarding investigations and incidents.

● Regular team meetings were not taking place and the staff did not have consistent opportunities to discuss best practice in a supportive environment.
● People told us they did not feel actively involved in the running of the service and they had limited opportunities to share their feedback.

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 manager understood their responsibility of duty of candour. Records confirmed the manager was open when incidents occurred.
● However, the investigations and analysis of incidents, for example falls were not always completed thoroughly until external agencies got involved.

Working in partnership with others
● The provider supported the manager by encouraging collaborative work with other care home' managers. At the time of our inspection, the manager told us it was helpful to learn from others and share experience.
● The service cooperated with health care professionals and external agencies, including the Local Authority and CQC.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failure to effectively assess and mitigate risk placed people at increased risk of harm.

The enforcement action we took:

We served a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to have effective systems or processes to assess, monitor and improve quality and safety impacted on people's health, safety and welfare.

The enforcement action we took:

We served a Warning Notice