The Fremantle Trust

Icknield Court

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
Icknield Court is a residential care home registered to provide personal care and support for up to 90 people. aged 65 and over. There were 50 people using the service at the time of the inspection.

The service accommodates people across two floors, each of which have separate adapted facilities. There were six 'houses' or 'units', three of which specialised in providing care to people living with dementia. At the time of the inspection two of the units were not being used to accommodate people.

People's experience of using this service and what we found
People were not always supported to keep safe. Risks to people's health and welfare were not routinely managed in a way that protected people from harm. Monitoring records such as repositioning, food and fluid charts and weight monitoring charts for people who were at risk of malnutrition were not always fully completed. In addition, staff were not always following the advice of healthcare professionals in relation to preventing and treating pressure ulcers.
People were not always supported by staff who followed best practice in the safe administration of medicines. Prior to and after our inspection we were alerted to a high number of medicines errors by the local authority. Although we did not find any medicines errors on the day of our inspection we did observe unsafe practice. During a medicines round where a member of staff did not wear gloves or wash their hands in between administering medicines to people. We also found that the controlled drugs register had not been completed accurately.

Accidents and incidents had not always been analysed so that lessons could be learnt, and action taken to prevent similar incidents from reoccurring.

Good systems were in place to prevent and control the spread of infection and the provider was following government guidance in relation to the Covid-19 pandemic.

There were robust staff recruitment systems in place and there were enough staff appropriately deployed to meet the needs of people using the service. Staff were committed to providing good care however, they were not receiving adequate support, guidance and monitoring from the management team to ensure they were effective in their roles.

The governance systems were ineffective and although some issues had been identified by the provider there were serious shortfalls at the time of our inspection that meant we could not be assured that people would receive safe and appropriate care.

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

Rating at last inspection and update

The last rating for this service was inadequate (published 20 January 2020) and there were multiple breaches of regulation. We served two warning notices following the inspection for Safe Care and Treatment and Good Governance. Following the inspection, the provider sent us an action plan telling us how they were going to address the shortfalls identified. During this inspection we found the warning notices had not been met and there were still breaches of regulation in relation to Safe Care and Treatment and Good Governance. The service remains inadequate.

Why we inspected
The inspection was prompted in part due to concerns received in relation to the management of medicines and people's care needs. We also needed to check what improvements had been made since the last inspection to address the breaches of regulation.

We undertook a focused inspection to review the key questions of safe and well-led only.

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

The overall rating for the service has remained the same. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Icknield Court 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. 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.

We have identified continued breaches in relation to safe care and treatment and good governance at this inspection.

Considering the exceptional circumstances, we have decided not to take any further enforcement action at this time. Following the inspection, we met with the provider and they have engaged external support to help drive improvement at the service. The provider has demonstrated a commitment to driving improvement at the service and will provide an action plan that will be monitored by us. A further inspection will take place shortly to ensure the required improvements have been made.

Follow up
We will continue to monitor information we receive about the service and the provider's action plan. We will then return and carry out a further inspection to ensure that the required improvements have been achieved. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. We will keep the service under review and will re-inspect in due course to check for significant improvements.

If the provider has not made enough improvement when we next inspect 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.

Icknield Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and a pharmacy inspector.

Service and service type
Icknield Court 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 our 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 reviewed information from Healthwatch. 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 spoke with the director of operations, the operations manager, the registered manager, the assistant manager, the deputy manager, and four members of the care team.

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 reviewed a range of records. This included four people's care records and additional records relating to their care. We reviewed medication administration records (MAR), the controlled drugs register and observed the administration of medicines. We also viewed accidents and incidents, audits of care plans and other records relating to the way the service was run.

After the inspection
We contacted 16 relatives by phone and sought clarification from the provider to validate evidence found. We asked for clarification about contact made with the GP. We spoke with one professional who regularly visits the service.

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

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

At our last inspection the provider had failed to adequately assess risks to people's health, safety and welfare. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvements had not been made and the provider is still in breach of Regulation 12.

•People were not always supported in a way that ensured they received safe care and mitigated any risks of avoidable harm. Information in care records was contradictory and incomplete for some people and staff did not always seek advice from or follow instructions provided by healthcare professionals to mitigate identified risks. For example, a community nurse had instructed staff monitor the fluid intake and output of one person with a catheter insitu due to previous urine retention. This was included in their care plan, however staff had failed to record this information which meant the person may have had urine retention without staff being aware. This could have had an adverse effect on their health and wellbeing. We raised this with the registered manager who told us this would be addressed immediately.
•One person's records showed they had not had their bowels open for eight days. We did not see any intervention or follow up about this in the records we viewed. We requested a GP was contacted during the inspection. We contacted the service the next day to enquire about the outcome of the GP conversation. The GP had not been contacted until the following day. This demonstrated a lack of staff awareness about the potential consequences for the person. For example, faecal impaction and abdominal pain.
•Risks posed to people as a result of poor skin integrity were not managed effectively which put people at risk of developing pressure ulcers. In addition, where people had developed pressure ulcers, staff were not routinely following the advice and guidance provided by community nurses. One person had a grade three pressure ulcer on their heel. The community nurse had advised staff to ensure a pressure relieving cushion was placed under the person's foot when they were sitting in a chair. We noted the person sitting in the dining room in the morning without the cushion placed under their foot. We relayed this information to the assistant manager who said they will reiterate to staff the importance of following specific instructions from healthcare professionals.
•We saw where people required repositioning due to skin damage and pressure sores they did not always receive the support they required. Records were incomplete and we could not be sure repositioning had taken place. One member of staff we spoke with told us this was not always carried out as expected. We saw two other examples where staff had not reported concerns about the condition of a person's skin and where staff were not following guidance from the community nurse. This put people at risk of their wounds and

health deteriorating.
•Risks associated with people's nutrition and hydration were not always appropriately managed. Food and fluid charts contained gaps and people's weight was not always monitored where there was an identified risk of malnutrition. For example, one person was at high risk of malnutrition and had a recorded weight of 34 kg, however, their food and fluid charts were incomplete. One food entry recorded the person had consumed a small amount of cereal at 8am and nothing else for the entire day. Staff were unable to tell us if the person had anything else to eat on this day. In addition, their care plan advised staff to weigh the person weekly but we saw gaps in the recording for this of three to four weeks on five occasions over the last five months.
•People using the service and staff were not always protected from the risks associated with people's mental health such as behaviours that challenged. Staff told us one person had to be supported by three staff when being assisted with personal care due to physically aggressive behaviour. Accident and incident records confirmed that the person had hit staff on several occasions. However, the person's care records stated they were independent and carried out their own personal care and did not mention any behaviour that challenged.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate people were sufficiently protected from avoidable harm. 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 were supported by staff who knew how to recognise potential abuse. Staff told us they had received training on safeguarding adults at risk.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were administered safely. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider was still in breach of regulation 12.

•People continued to be placed at risk from unsafe medicines management. During our inspection we followed up concerns relating to a safeguarding referral of neglect/acts of omission by staff regarding 40 medicine errors for people living at Icknield Court between 5 January and 25 March 2020. Although we did not identify any medicine errors on the day of the inspection, following our inspection we were informed by a health and social care professional that there had been over 40 additional medicine errors reported to the local authority by the provider between May and July 2020. These errors ranged from one person receiving medicine intended for another person to people not receiving their medicines as prescribed. Therefore, further action was required to address this and mitigate the risks to people from the unsafe management of medicines.
•People were not routinely supported by staff who followed best practice guidance for safe administration of medicines. We observed a medicine round and saw that the administrator had not washed their hands between each person and was not wearing gloves as required.
•We checked controlled drugs and found the controlled drugs register incorrectly completed. For example, several obliterations and stock of morphine were still showing on the register when it had been returned to the pharmacy. Fridge temperature records were inconsistent and temperatures were not always recorded correctly.

• People's care records did not always accurately reflect the medicines they were prescribed. We saw that one person's care plan made reference to them having dementia and stated they were not on any medicine for this. However, medicine records we saw confirmed the person was prescribed medicine related to their dementia.
We found no evidence that people had been harmed however, systems were not robust enough to ensure the proper and safe management of medicines. 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.

Staffing and recruitment

At our last inspection the provider had failed to deploy sufficient numbers of staff to make sure people's care needs were met. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18

•The service had an ongoing recruitment programme and used agency staff on a regular basis to cover shifts. We saw there were two staff on each unit to deliver care. An additional member of staff was responsible for the administration of medicines. A support worker was available to assist with meals. The provider had employed senior staff to assist with the ongoing monitoring of the units.
•People were protected from being cared for by unsuitable staff as the required pre-employment checks were carried out before new staff started work. This included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions by helping to prevent unsuitable people from working with people using care services.

Preventing and controlling infection
•The service was cleaned to high standards and we saw correct personal protective equipment (PPE) was used throughout the service. Staff were following government infection prevention and control guidance in relation to the Covid-19 pandemic. This ensured staff were confident and competent in keeping people safe from the risks of infection.

Learning lessons when things go wrong
•Accidents and incidents were recorded when incidents occurred. However, there was limited evidence that to demonstrate that analysis of these events had taken place to identify trends and ensure action was taken to prevent a reoccurrence.

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. 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.

At our last inspection the provider had failed to ensure systems to monitor and improve the quality of the service were effective. Which meant that people were at risk of receiving a poor service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider was still in breach of regulation 17.

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

- Risks associated with people's health and welfare were not always mitigated as the provider's systems for identifying and managing risks were not effective. Where staff were not taking appropriate action to mitigate risks for example in relation to pressure area care, nutrition, hydration and safe medicines management, these issues were not always identified and addressed in a timely manner.
- We found records were not being routinely checked to ensure staff were completing these as expected. For example, there were significant gaps in repositioning, food and fluid charts and records of people's weight were not always maintained as required where people were at risk of malnutrition. In addition, the management team had failed to identify that staff were not following guidance provided by healthcare professionals to ensure people were protected from avoidable harm and their needs met.
- Audits undertaken did not effectively drive improvement. The audits seen during our inspection did not contain actions or an outcome and therefore we could not be assured any action had been taken to address the shortfalls identified. Prior to our inspection the provider had carried out a mock inspection of the service. We viewed the report from this inspection and noted that some of the issues that we had found had been identified. However, this was two months prior to our inspection and action had not yet been taken to address these issues effectively.
- The provider had not been able to make or sustain improvements since the last inspection and the requirements in warning notices served for Safe Care and Treatment and Good Governance had not been met. In addition, the registered manager did not immediately follow up concerns we identified during the inspection. For example, we asked if a doctor could be contacted as we were concerned about a person who had not had their bowels opened for eight days. This was not done until the following day. Therefore, we could not be assured that the management team were effectively responding to issues and concerns that were negatively impacting people's health and welfare.

We found no evidence that people had been harmed however, systems were not robust enough to

demonstrate that governance of the service was effectively managed. This placed people at risk of receiving unsafe or ineffective care. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

●People using the service, their relatives and staff did not always feel able to openly raise and discuss concerns and felt communication could be better. We had received concerns from two whistle blowers before we carried out the inspection. Both of them wanted to remain anonymous for fear of reprisals. Therefore we could not be assured that the service responded to concerns in a positive or transparent manner.

●One member of staff we spoke with told us they had told management about some concerns they had in relation to poor care. The member of staff said this was brushed aside and they were told to "just get on with it". We observed that staff were trying to provide care to the best of their ability, however, they were not receiving the support and guidance from the leadership team to enable them to do this effectively.

●Relatives said they were mostly happy with the care their family member received. However, some relatives told us they had not raised issues because they didn't want to make a fuss. One relative told us they had not been told that garden visits were now available. They said they were told about this by someone who visits the service.

●Another relative told us she had been told their father may have a serious health condition as they were just about to leave the premises. The deputy manager then asked if they were next of kin. The relative told us they were shocked that this was asked after the news was given about their father. The relative went on to say "things are a bit prickly now".

●Another relative we spoke with was quite critical about the lack of communication from the registered manager about issues affecting their mother's care. They told us the situation had caused a lot of stress and it had taken a long time to get the issues resolved. The relative did however say that overall, they had found care staff had supported their mother with "dignity, kindness and warmth".

●We discussed concerns raised by relatives and staff with the registered manager and she said she was upset that staff had not told her about the issues.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

●The provider had engaged with people using the service, their relatives, representatives and staff around changes made to manage the risks associated with the Covid-19 pandemic. This had included changes to visiting and infection prevention and control procedures in line with Government guidance.

●Following the inspection, we met with the provider and they told us they were committed to developing a robust action plan and fully engaging staff, people using the service and relatives in this process to drive the required improvements at the service.

●We saw evidence that the provider worked with external agencies such as health and social care professionals to help meet the needs of people using the service. However, staff were not always following the advice of these professionals to ensure people received safe and appropriate care at all times.

Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

●Providers are required to comply with the duty of candour statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment,

including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity. The registered manager was familiar with this requirement and was able to explain their legal obligations in the duty of candour process

- During the inspection we identified continued concerns around safe care and treatment and good governance. Improvements had not been sustained and issues of concern were not always identified and addressed in a timely manner. Therefore, we could not be assured that an effective system of continuous learning and improvement was being operated. We met with the provider following the inspection. Immediate steps had been taken to review practice at the service and an action plan was being developed to address the concerns.