Mi Care Wicksteed Court Ltd

Wicksteed Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
On 24 July 2019 the provider applied to change the name of the service from Holly House Residential Care Home to Wicksteed Court Care home. The nominated individual for the service remained the same and the service continued as Wicksteed Court Care home.

Wicksteed Court Care Home is registered to provide accommodation for persons who require personal care, for up to 26 older people in a converted building. At the time of inspection 15 people were using the service.

People's experience of using this service
We found evidence of ineffective systems and processes regarding how the provider delivered and monitored the quality and safety within the service. This meant there was limited oversight of the safety of the service.

Known risk's to people's safety were not always identified, assessed and managed. The provider's failure put people in the service at risk of harm.

Peoples personal emergency evacuation plans (PEEP's) did not always contain the information required for staff to support them safely in the event of an emergency.

People did not have appropriate risk assessments for the use of equipment. This meant effective strategies were not in place to reduce the risk of harm to people using the equipment.

Safe staff recruitment processes were followed to protect people from unsuitable staff. However, staff had not received comprehensive inductions. Staff had not been suitably trained to support people safety.

There were not always enough staff to meet people's needs. People and staff told us that additional staff were needed.

Improvements were needed with infection control.

People did not always receive person centred care. People's care files did not always contain the necessary information and staff had not read people's care files.

People's records were not completed fully and there were gaps in people's repositioning charts.

Daily activities were limited and during our inspection we saw limited interactions between staff and people.

People were mostly supported to have 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.

Medicine had been given as prescribed.

People's relatives and staff told us they knew how to make a complaint.
There were procedures in place for making compliments and complaints about the service.

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 requires improvement (17 July 2019).

Why we inspected
The inspection was prompted in part due to concerns received about staffing. A decision was made for us to bring the inspection forward to inspect and examine those risks.

Enforcement
We have identified breaches in relation to safe care, person centred care, staffing, staff training and oversight 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
The overall rating for this service is 'Inadequate' and the service is therefore 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 time frame. 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Wicksteed Court 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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Wicksteed Court Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. However, a manager had been appointed and was going through our registration process. A registered manager is a person who is legally responsible for how the service is run and for the quality and safety of the care provided. It is a requirement of the provider's registration that they have a registered manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection, which included any notifications that had been sent to us. A notification is information about important events which the provider is required to send us by law.

We sought feedback from the health and social care commissioners who monitor the care and support that people receive.

We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and three people's relatives. 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 also spoke with six members of staff, including care staff, and the manager.

We looked at various records, including care records for five people. We also examined records in relation to the management of the service such as staff recruitment files, quality assurance checks, staff training and supervision records, safeguarding information and accident and incident information.

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 Good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People were at risk as systems and process were not in place to protect people from harm. Risk assessments had not been fully completed with risks and strategies for the use of bed rails and choking. This meant there were no preventative strategies put in which increased the risk of harm to people.
- Due to the serious risks posed to others by one person who used the service, one to one staffing was judged to be the most suitable way to mitigate the risk. The provider had failed to implement the strategies to mitigate this risk, and their failure put people in the service at increased risk of harm.
- The provider had failed to identify and manage some known risks. These failures put people at risk of scalding. For example, some radiators had covers, other did not. One person's en-suite toilet had a hot water tank and hot pipes accessible. Staff did not check the water temperature before supporting someone to have a shower. There were limited temperature checks in place to ensure the water did not exceed the recommended temperature.
- Environmental and equipment risks had also not been addressed. For example, people had access to the laundry which housed cleaning product's, wardrobes were not attached to the wall. People's personal evacuation plans (PEEPs) were out of date and information recorded was conflicting. A PEEP is a bespoke escape plan for individuals who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of any emergency. Due to these risks not being identified, people were placed at risk of harm.
- People were at risk of skin damage. For example, one person who was identified as at risk of pressure sores did not have a care plan in place to reduce this risk. Another person who required staff to support repositioning did not have this documented. So, it was unclear they had received the care and support they required.
- Staff we spoke to all stated they had not had time to read through people's care plans or risk assessments.

The provider had failed to assess the risks to the health and safety of people using the service, or take action to mitigate risks, this is a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

After the inspection, the provider told us of the steps they had taken to mitigate the risks we had identified. These included, putting risk assessments in place for the areas identified, ordering equipment to protect people from harm regarding bed rails and scalding, fitting a lock to the en-suite bathroom door, checking and attaching all wardrobes to walls. The provider removed the washing detergent from the open room and implemented a new system of recording and reporting water temperatures.

Staffing and recruitment

● Staff told us there were not enough staff on shift. On the day of inspection one person waited for 26 minutes before staff supported them to use the toilet.
● The staffing rotas evidenced that at times there were not enough staff on shift to meet the needs of the people living at Wicksteed Court Care Home. For example, during a period of three weeks; eight shifts had two staff on the rota, 24 shifts had three staff on the rota and 10 shifts had four staff on shift. The staff were required to support 15 people, one person required constant one to one support from staff as well as six people who required two to one support for manual handling needs.
● We saw that the communal areas were not always staffed appropriately. For example, people were in the lounge with no access to a call bell should they need support and staff were not present for long periods of time.

The provider failed to ensure there were enough numbers of staff deployed to meet people's assessed care and support needs. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

● Staff had been recruited safety. Staff files evidenced pre-employment checks were completed.

Preventing and controlling infection
● On the day of inspection, we found some bedrooms did not have hand soap or towels. This meant that staff would be unable to wash their hands immediately after completing tasks. The provider installed soap dispensers after the inspection.
● Staff told us that they had access to personal protective equipment (PPE) such as gloves, and aprons.

Learning lessons when things go wrong
● The provider did not have sufficient systems in place to identify where things went wrong. This meant there was not enough information to analyse the cause of incidents in a timely way.
● The provider did not have systems to identify where people could be at risk of environmental issues, or processes to take actions to mitigate the risks.

Using medicines safely
● Medicines were managed safely. However, training records did not identify which staff had received medicine training or who had their competency assessed.
● People received appropriate support with their medicines. We looked at people's medication records and this evidenced that staff managed medicines consistently and safely.
● Staff responsible for administering people's medicines knew what action to take if they made an error.

Systems and processes to safeguard people from the risk of abuse
●Staff were knowledgeable about the types of abuse and the actions they should take if they had any concerns that people were at risk.
● The provider had effective safeguarding and whistleblowing systems and policies in place.
● The registered manager was aware of their responsibility to liaise with the local authority if safeguarding concerns were raised.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.

- People had comprehensive pre- admission assessments completed. These documents are to ensure the service can meet people's individual needs. However, for one person this information had not been transferred into a care plan or any risk assessment. Therefore, staff did not have the required information to meet the person's needs consistently and safely.
- We saw two people being supported to eat, who did not have their dentures in place. There were no risk assessments or recorded reasons identified why they should not have their dentures in use. We saw no evidence that this was due to their preferences, to reduce a specific risk or had been discussed with them.
- One person was given a pureed diet, however there was no record of the reason and their care plan stated, 'normal texture.' The registered manager explained they were at risk of choking. We saw no evidence of this risk being identified and there was no risk assessment in place to ensure staff knew how to deliver care and support safely.
- People were not fully supported with oral health. Care files did not contain detailed information regarding people's oral healthcare needs.
- We found that one person's dentures were kept in dirty water in a tub, which placed them at risk of oral infection.

The provider had failed to ensure people received person centred care, this is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

Staff support: induction, training, skills and experience

- During the inspection we identified some incorrect manual handling techniques used by staff. Some staff told us they had not received manual handling training. However, the provider told us that some basic elements of moving and handling were covered in the care staff induction.
- The training matrix in place did not identify when staff received all mandatory training. Not all staff were adequately trained. Some staff told us they had not received medicine training but had been administering medicines.
- Staff induction included reading care plans and risk assessments as well as getting to know the service. However, one staff member told us, "I was taken around the building, I was not given any time to read care plans and my one shadow shift I was used as the second staff member for people who needed two staff to support them." Another staff member told us they were not given training before starting to work alone with people.
- We received mixed views from staff on support offered to them. One staff member told us, "I feel

supported." Another staff member said, "There is no support or supervision given by managers to new staff, it is left to the staff to manage."

The provider failed to provide the training and support required to enable staff to carry out their roles. This is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● People had their capacity assessed for specific decisions. Best interest paperwork had been completed however this did not always contain information regarding who had been involved.
● We saw some examples of conversations held with relatives about photos and video being used on the providers website.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff were aware when people had dietary concerns and supported people to have those needs met.
● People told us the food provided was good and that they had a choice of meals.
● When required, people were weighed regularly to ensure they remained healthy.

Supporting people to live healthier lives, access healthcare services and support. Staff working with other agencies to provide consistent, effective, timely care
●We saw evidence within people's care files of healthcare professionals being involved for specific reasons. However, for one person who the service identified as a choking risk regarding food and their dentures. There were no recorded referrals to speech and language therapy [SALT] or the dentist. The provider made a referral to SALT after the inspection.
● Staff recognised when people required medical help and contacted the GP and ambulance services as appropriate.
● The doctor and opticians visited the home regularly.

Adapting service, design, decoration to meet people's needs
● The service had camera's which have an audio function. This meant that the provider could watch and listen to areas of the home. A policy was in place to identify why these were used. The provider reviewed the impact camera's and audio function had on people using the service yearly.
● People had personalised their rooms to their own taste.
● The service had dementia friendly signs within the home to support people to orientate themselves around the building.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

At our last inspection the provider had failed to protect people's privacy. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was now meeting this regulation.

Ensuring people are well treated and supported; respecting equality and diversity
- People told us staff did not always engage with them as they were too busy. One person said, "Staff sometimes chat with me." Another person said, "They have no interest in me."
- People told us that most staff were kind, however a relative and two members of staff told us that some staff ignored people at times, this included if they needed support to use the toilet or to move to different room.
- During the inspection we saw limited interactions between staff and people.

Supporting people to express their views and be involved in making decisions about their care
- We saw no evidence of resident meetings occurring. However, three relatives told us that they were able to give feedback on the service as required.
- Care files had details of who had been involved in planning care and had given consent. For example, the person or their representative.
- People's choices of their preferred gender of staff to complete personal care tasks had been recorded.

Respecting and promoting people's privacy, dignity and independence
- One person's bedroom had been used to store the homes light fitting boxes and old sky equipment.
- Staff could tell us how they would protect people's privacy and gave examples such as closing doors when assisting with personal care and knocking before entering a bedroom.
- A relative told us that they felt their loved one's independence had improved.
- People's information was stored securely within the office, and all staff were aware of keeping people's personal information secure.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences. Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's care plans did not always reflect their current needs, they had not been regularly updated.
- People did not always have choices regarding their care. For example, one person told us, "It depends on what staff are doing to whether I can have a shower." Another person said, "They [staff] tell me it's not what you want but what I say."
- People told us and on the day of inspection we saw, that activities were very limited. One person said, "No activities, they don't tell you what they are doing." Another person said, "Nothing to do." The provider had purchased an interactive cat and dog for robotic pet therapy, however on inspection we saw that although people could access them, staff did not support people with these interactions.
- One person's bedroom had been used to store the homes light fitting boxes and old sky equipment.

The provider failed to ensure all people received care that met their needs and preferences. This is a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care

- Most care plans had a section 'All about me' which detailed information about the person's history, family names and previous work settings.
- Relatives told us they were able to come and see their loved one whenever they wanted to, and that staff were always accommodating towards them.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were documented within their care plans.
- We saw some information had been made into an accessible format.
- Pictorial signage had been placed throughout the home to signpost people to key areas such as the dining room, bedrooms and bathrooms.

Improving care quality in response to complaints or concerns

- There was a complaints policy and procedures in place. Staff and people's relatives told us they knew how to complain.

● Two members of staff told us of multiple complaints they had made to the provider, however we did not see any evidence of these being logged. The provider told us that they had not received any complaints since the last inspection.

End of life care and support

● At the time of the inspection there was no one who required end of life care.

● Some end of life care plans were comprehensive while others did not contain any end of life details. The provider had not recorded when a person had refused to share this information.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. 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. Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There were limited systems in place to assess and monitor the safety of the home, placing people at risk of injury, infection and harm. Monthly audits had not been completed since November 2019, which meant the provider did not have an oversight of the needs of the people living at the service.
- The provider had failed to keep complete and accurate records for each person's care. One person had no care plan or risk assessment in place covering their needs. Handover information did not always include up to date information and daily notes did not contain information in line with the providers procedures. For example, they did not always contain information on people's food and fluid, participation in activities and timings of events. Outcomes for people had not been identified and subsequently person-centred care had not been delivered.
- The provider did not have an overview of staff training and performance. The training matrix did not show which staff had received training. Therefore, the provider could not be assured that staff had received all the required training.
- We saw no evidence of spot checks or medicine competency assessments being completed, the manager confirmed these had not taken place. This showed that there was significant shortfalls in supervision of staff performance.
- The provider did not have a dependency tool in place to identify the staffing needs for the whole service. Staff and people told us there was not enough staff on duty. The rota evidenced that at times they had understaffed the service which put people at risk of harm.
- The service did not have a manager registered with the Care Quality Commission. However, a manager had been appointed and was going through our registration process

The provider failed to have systems and processes in place to assess, monitor and mitigate the risks relating to health, safety and welfare of service users, or have systems to improve the quality and safety of care. This is a breach of Regulation 17, Good governance.

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 told us they understood, and would act on, their duty of candour responsibility.

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

characteristics

● Staff meetings had not been held regularly. However, we saw the most recent meeting minutes and they evidenced that the manager had implemented some changes and communicated these to staff.

● The provider had gathered people's views of the service in the form of a survey. These results were collated and displayed in a communal area.

●Three people's relatives told us they were kept up to date if any changes occurred to their relatives.

Working in partnership with others. Continuous learning and improving care

● Representatives from the local authority quality team had conducted a monitoring visit and identified concerns with the service. The manager was working with the local authority to make the improvements needed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure all people received care that met their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were enough numbers of staff deployed to meet people's needs. The provider failed to provide the training and support required to enable staff to carry out their roles.

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 Risk to people's safety were not always identified, assessed and managed.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been followed to ensure the provider delivered and monitored the quality and safety within the service.

The enforcement action we took:

Warning notice