Interhaze Limited

# Wheatsheaf Court 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 effective? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

About the service
Wheatsheaf Court Care Home is a nursing home providing accommodation and personal care to up to 55 older people and people with dementia. At the time of inspection there were 38 people living at the service.

People's experience of using this service and what we found
There were insufficient systems in place to assess, monitor and improve the service. The governance and oversight in place had not identified the concerns found at this inspection.

The provider failed to identify or manage risks posed by people's health conditions. People living with insulin dependent diabetes did not receive safe care which put them at risk of harm.

Medicines were not managed safely; processes were not in place to ensure people's medicines were safely administered.

People's care plans and risk assessments did not always reflect people's current needs.

Environmental risks and food safety needed to be addressed to ensure people were not at risk of harm. People were not always protected from the risks associated with infection because the service did not consistently implement processes to reduce the risk of infection and cross contamination.

People did not always receive person centred care that considered their individual needs. The support provided to people at mealtimes continued to need improvement. Staff did not support people with their meals in a person centred, timely way. The provider had not always ensured people were supported with visiting in line with government guidance.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

People told us staff were deployed in sufficient numbers to meet their needs and they did not have to wait for their care.

Staff knew people well and understood how to protect them from abuse. There were policies covering adult safeguarding, which were accessible to all staff.

Staff felt supported within their roles and felt confident to discuss any concerns they may have with the manager.

There was a positive and inclusive culture, feedback was sought from people, relatives and staff to identify

where improvements were needed.

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 requires improvement (published 25 September 2019) and there was a breach 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 the provider remained in breach of regulations. The service remains rated requires improvement. Since 2017 this service has been rated requires improvement twice and inadequate once.

Why we inspected
The inspection was prompted in part due to concerns received about staff knowledge, management of medicines, responding to people's medical needs, person centred care and infection prevention and control. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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 overall rating for the service has not changed following this focused inspection and remains requires improvement. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wheatsheaf Court Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, person centred care and governance and leadership at this inspection.

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 continue to monitor information we receive about the service, which will help inform when we next inspect. We will work with the local authority to monitor progress.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

**Is the service effective?**

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

**Is the service well-led?**

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

# Wheatsheaf 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 Health and Social Care Act 2008.

Inspection team
The inspection was carried out by 1 inspector and an expert by experience who made telephone calls to relatives of people who lived at the service. 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
Wheatsheaf Court Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was no registered manager in post. However, a manager was in post and they were planning to register as manager for the service.

Notice of inspection

This inspection was unannounced.

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

During the inspection
Some people found it difficult to communicate with us about their experiences of support due to their complex support needs. 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 spoke with 4 people and 8 relatives of people who used the service about their experience of the care provided. We spoke with 8 members of staff including the manager, nursing staff, care staff, kitchen staff and maintenance staff. We reviewed a range of records. This included 4 people's care records and multiple medication records. We looked at 5 staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

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 as requires improvement. At this inspection the rating 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.

At our last inspection the provider had failed to ensure people were protected by the prevention and control of infection. This was a breach of Regulation 12 (1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had not made enough improvement and was still in breach of regulation 12.

Assessing risk, safety monitoring and management

- Risks to people were not always identified or managed safely.
- The provider failed to identify or manage risks posed by people's health conditions. People living with insulin dependent diabetes did not have care plans that reflected their current needs or inform staff how to mitigate known risks associated with the person's diabetes. Staff did not always monitor people's blood glucose effectively, this meant two people experienced prolonged periods of high blood glucose which placed them at increased risk of serious medical conditions.
- Staff did not have sufficient information about people's risk of falls and nutritional risks. This put people at risk of unsafe care. One person had experienced a high number of falls and insufficient action had been taken to mitigate the risks.
- Environmental risks such as falls from height had not consistently been monitored or managed safely. Although some action had been taken to limit the opening of windows on the first and second floor, this was not in line with guidance issued by the Health and Safety Executive. No risk assessment had been carried out to ensure the measures the provider had taken to mitigate the risk of falls from windows were sufficient.
- Food safety risks were not consistently managed. Meals were cooked at a central site, refrigerated, and delivered chilled to the home. Temperatures of the food required checking on arrival to ensure they had been transported at a safe temperature, this was not consistently carried out. There was a risk people would be served food that was not safe to eat.

Using medicines safely

- Where people had their medicines administered covertly (disguised in food or drink) the provider had not ensured appropriate medical professionals had been consulted to ensure this method of administration was safe. Some medicines can become ineffective when mixed with certain foods or drink and altering the characteristics of a medicine may change a person's response to that medicine. Failure to assess the risks related to the crushing of medicines and mixing with food placed people at risk of harm.

Preventing and controlling infection

- At the last inspection, we were not assured the provider was making sure infection outbreaks were effectively prevented or managed as government guidance in relation to testing for COVID-19 had not been

followed during an outbreak. At this inspection we found government guidance continued to not be implemented correctly.
● We were not assured that the provider was supporting people living at the service to minimise the spread of infection. During an outbreak of COVID-19, government guidance in relation to supporting people who had tested positive for COVID-19 to isolate from others had not been effectively implemented.
● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. Some areas of the home and equipment were visibly dirty. This posed a risk of cross contamination.
● At the last inspection we were not assured that the provider's COVID-19 policies and procedures were either in place or provided staff with clear guidance specific to the home. At this inspection we found COVID-19 policies continued to not be updated in line with government guidance.

We found no evidence that people had been harmed however, risks to the health and safety of people using the service were not effectively managed, action was not taken to mitigate risks and medicines were not administered safely. These were all breaches of regulation 12 (1) (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.

Visiting in care homes

At our last inspection the provider had not always ensured people were supported with visiting in line with government guidance. Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 9.

● The provider had not followed government COVID-19 guidance on care home visiting during an outbreak as the home had been closed to visitors for one week.

This was a continued breach of Regulation 9 (1) (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff were deployed in sufficient numbers.
● People told us they thought enough staff were deployed to meet their needs. One person said, "The staff are very friendly, if I need anything I call them, and they come."
● People's relatives told us they thought there were plenty of staff available to meet their family members' needs. One person's relative commented, "I've not made appointments, just turned up, there is a good staff ratio always." Another person's relative said, "I think there are enough staff, always somebody around."
● People were safeguarded against the risk of being cared for by unsuitable staff because there were appropriate recruitment practices in place. Staff were checked for any criminal convictions and satisfactory employment references were obtained before they started to work at the home.

Systems and processes to safeguard people from the risk of abuse
● Staff knew people well and understood how to protect them from abuse. There were policies covering adult safeguarding, which were accessible to all staff.
● Staff had received up to date safeguarding training and understood the procedures they needed to follow

to make sure people were safe. Staff were able to explain the procedure they would follow to report safeguarding concerns if they were concerned a person was being abused.
● People told us they were safe. One person said, "I feel safe, definitely I do, the staff are lovely." Another person's relative told us, "I feel [Person's Name] is safe and well cared for. The nurses are calling in on a regular basis."

Learning lessons when things go wrong
● The manager reviewed incidents and used feedback from people and staff, to improve safety across the service. This learning was shared with staff to improve practice.

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last two inspections the provider had failed to provide the individual support people needed to eat their meals. This was a breach of Regulation 9 (1) (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had not made enough improvement and was still in breach of regulation 9.

Supporting people to eat and drink enough to maintain a balanced diet

- People did not receive personalised support at mealtimes, that met their social and nutritional needs.
- During an observation of the mealtime service we saw that lunch service was chaotic. People did not receive individualised support and were left waiting for their food.
- Staff did not engage with people while they supported them to eat and frequently left the people, they were supporting to take meals to others. For example, staff left one person part way through supporting them with their meal, which would have been cold by the time other staff came to support them to continue eating.

People were not provided with the individual support they needed at mealtimes. This was a continued breach of Regulation 9 (1) (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were supported to make choices for meals and drinks. They told us they enjoyed the food provided and were offered regular drinks and snacks.
- People's weight was monitored, and high calorie foods provided if people were losing weight.

Staff support: induction, training, skills and experience

- Improvements were required to the measures in place to ensure staff were fully trained and provided with regular supervision.
- The service provided care to people with epilepsy, but staff had not received training in supporting people with epilepsy. There was a risk staff would lack the knowledge and skills to meet the needs of a person experiencing a seizure. These concerns were raised with the manager, and they have arranged for staff to receive training in epilepsy.
- Staff had not received regular supervision in line with the provider's policy. Records showed supervision meetings had been provided to staff on an inconsistent and infrequent basis. However, staff told us they felt supported in their roles and senior staff were available to them to provide support.

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 MCA 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Mental capacity assessments were not consistently carried out where the information available indicated people may lack the mental capacity to consent to their care. For example, in relation to diabetes and medicines. Staff could not be sure care was being provided in people's best interest.
● MCA assessments had not been completed with the relevant persons and healthcare professionals to make a best interest decision where people needed to take their medicines covertly. We discussed our concerns with the manager and they took action to ensure people had mental capacity assessments and best interest decisions in place as required.
● The provider had assessed people to see if they were at risk of being deprived of their liberty and had made DoLS applications for a number of people.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed before coming to live at the home. However, the information gained during the assessment was not always updated correctly in care plans and risk assessments, these documents did not contain updated, factual information.
● People living with long-term conditions did not have their conditions assessed, monitored or managed in line with best practice guidance. The provider failed to have systems in place to implement best practice in the care of diabetes. This placed people at risk of unsafe care.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The provider monitored people's health, care and support needs but did not consistently act on issues identified. For example, to refer people with diabetes to the GP or specialist diabetic services where there were concerns about the management of their condition.
● Records showed, where it had been recognised people would benefit from access to health professionals such as dietitian, speech and language therapist and chiropodist this had been arranged.

Adapting service, design, decoration to meet people's needs
● Wheatsheaf Court Care Home was a Grade II listed building which has been adapted to provide accommodation over three floors. At the time of the inspection refurbishment was ongoing to provide more communal space and redecorate bedrooms.
● People's rooms were personalised to their tastes and preferences.

- People had access to an outside courtyard area.

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 requires improvement. At this inspection the rating for this key question has remained 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.

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; Working in partnership with others

- Concerns identified in previous inspections in relation to infection prevention and control practice and person-centred care had not been addressed and continued to be of concern at this inspection.
- The governance and oversight of the care of people with insulin dependent diabetes was ineffective. People living with diabetes were placed at risk of ill health because there was a lack of effective oversight of their care.
- Systems in place to drive improvement and ensure people received individualised, person centred care were ineffective and people continued to experience poor quality support during mealtimes.
- Oversight of medicines was ineffective, and systems had not been implemented to ensure people's medicines were administered safely.
- There was a lack of oversight of the environment and food safety.
- There was poor governance and a lack of ongoing monitoring of care documentation. People's care plans and risk assessments contained incomplete information about people's risks and requirements in relation to behaviour, wound care and nutrition and hydration needs. There was a risk people would not receive appropriate care to meet these needs.
- There was poor governance and oversight where people required their mental capacity to be assessed. Mental capacity assessments were not consistently carried out where the information available indicated people may lack the mental capacity to consent to their care.
- The systems and oversight in place to ensure staff received regular supervision, and training in all areas required were ineffective.
- Audits and other processes in place to manage the governance of the service, were not carried out fully, consistently, or in line with the provider's meeting and audit schedule. For example, falls audits were not completed as scheduled.
- Policies and procedures in place to guide staff in the management of COVID-19 were incorrect as they had not been updated in line with government guidance.

The oversight and governance of the service was not effectively managed. This was a breach of regulation 17(1) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

characteristics; Continuous learning and improving care

● The manager was planning to register with CQC and had begun to make improvements to the service. People and relatives said communication from the manager was good, they were accessible and listened to people. One person's relative said, "I know I will be listened to and have been, anything I ask is sorted out" And "[Manager] has a friendly relationship with us and asks us if we have any concerns. They will ring up or I will pop in. They are all very keen to do their best for the residents."

● Regular meetings had been held, for people to share their views and contribute to the running of the service. Minutes of these meetings were available and showed action was taken in response to people's feedback.

● Regular meetings took place for staff. Minutes were available for these meetings.

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 was open and honest when things went wrong, they informed families and external agencies as needed.

● The provider notified the Care Quality Commission (CQC) of events they were required to by law and had displayed their previous inspection rating as required.

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 9 HSCA RA Regulations 2014 Person-centred care |
| Treatment of disease, disorder or injury | The provider had not followed government COVID-19 guidance on care home visiting during an outbreak.<br><br>People were not provided with the individual support they needed at mealtimes. |

**The enforcement action we took:**

Warning notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | Risks to the health and safety of people using the service were not effectively managed, action was not taken to mitigate risks and medicines were not administered safely. |

**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 |
| Treatment of disease, disorder or injury | There were insufficient systems in place to assess, monitor and improve the service. The governance and oversight in place had not identified the concerns found at this inspection. |

**The enforcement action we took:**

Warning notice