Bcs Medical (Shackleton) Ltd

Shackleton Medical Centre

Inspection report

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27 January 2022

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Ratings

Overall rating for this service	Inspected but not rated
Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

Shackleton Medical Centre is a care home that can provide accommodation and personal or nursing care for up to 26 people with both nursing and general care needs and end of life care. At the time of the inspection there were 25 people living at the care home.

We found the following examples of good practice.

• The provider had processes in place to manage any outbreaks. This included caring for people in their bedrooms if they tested positive and PPE was available outside the room with a way for staff to dispose of used PPE safely. On the day of the inspection a COVID 19 outbreak was identified and we observed this process had been followed by staff.
• The provider had a process for COVID-19 testing of both people living at the home and staff but the records to show the results of PCR tests were not always completed in full to indicate the outcome and the date received.
• There was a procedure to ensure visitors to the home were prevented from catching or passing on an infection. Visitors could show proof of an COVID-19 test on arrival or do a test at the home and wait for the result.
• The activities coordinator confirmed, during a COVID19 outbreak, they visited each person in their bedroom to identify any one to one activities the person was interested in to reduce the risk of isolation.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

Further information is in the detailed findings below.

Shackleton Medical Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We received information of concern about visiting arrangements at this service. This was a targeted inspection looking at the infection prevention and control measures and the visiting arrangements the provider has in place. We also asked the provider about any staffing pressures the service was experiencing and whether this was having an impact on the service.

This inspection took place on 27 January 2022 and was announced. We gave the service one days' notice of the inspection. Following the inspection, we spoke with five relatives to obtain their views on the visiting processes at the home.

Inspected but not rated

Is the service safe?

Our findings

Staffing
• The provider told us they had measures in place to mitigate the risks associated with COVID-19 related staff pressures.

How well are people protected by the prevention and control of infection?

At our last inspection the provider had failed to ensure that systems were in place or were robust enough to demonstrate infection control was always effectively managed. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.
• The provider did not ensure risk assessment and management plans in relation to COVID-19 had been developed for people living at the home and staff. Risk assessments for people using the service and staff should identify any specific issues which could impact on the person's health.
• Risk assessments had not been developed for people who went into the community to identify any increased risks and to put in place any actions and support for the person to reduce those risks in relation to COVID-19.
• Therefore, the provider was unable to ensure appropriate actions were put in place to reduce possible risks of infection for both people living at the home and staff.
• The provider supported staff and people living at the home to undertake regular COVID-19 testing but the records were not always completed to indicate the outcome of the test and when the results were received, which meant the provider was unable to monitor if the results had been received in a timely manner.
• The provider did not have an enhanced cleaning schedule to ensure communal areas and touch points around the home to reduce the risk of transfer of infection. There were cleaning records on bedroom and stairwell doors to indicate when the door handles were cleaned. These indicated that door handles should be cleaned once a day, but the schedules showed that this had not always happened. The records for one door indicated that over a period of 20 days the door handle had been cleaned on 16 days. This had not been monitored to ensure the handles had been cleaned in line with the provider's process.

The provider had not put in place appropriate and robust processes to reduce the risks of infection. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People living at the home were supported to have visits from relatives and friends, but concerns were raised by a relative in relation to issues with them trying to arrange visits to the home and not being able to become an essential care giver. Government guidance states that every person living in a care home should be supported to have an identified essential care giver who may visit the home to offer companionship or help with care needs. Essential care givers are able to visit inside the care home even during periods of

isolation and outbreak, providing the essential care giver does not have COVID-19. During the inspection we asked the acting manager if any relatives had been identified as an essential care giver and they confirmed when a request had been received it had not been actioned. Also people and their relatives had not been informed of the essential care giver role as an option so they could decide if it would beneficial to provide additional support.
• Following the inspection, we spoke with five relatives of people living at the home. All five relatives confirmed that they were not aware of the essential care giver role. Three of the relatives we spoke with also confirmed they had experienced issues when trying to arrange a visit to the home. They confirmed that visits were limited to two time slots per day which made it difficult for relatives that worked to arrange weekday visits. Also, visits had been cancelled at short notice as the relative had been informed there had been a double booking for a specific time slot. Relatives also explained they were unable to visit the person in their bedroom and visits were carried out in the ground floor entrance area with the relative sitting outside or in the activities room. The guidance states that visits should occur in an area where the person feels comfortable, which would usually be their bedroom. This meant people and relatives were not being supported in line with the guidance to help prevent social isolation.
• The acting manager confirmed following the inspection that one relative had been supported to become an essential care giver and the other relatives had been informed about the role. Also, when visits were restarted following the COVID-19 outbreak people were supported to meet with their visitors where they felt most comfortable which included their bedroom.

The provider had failed to carry out risk assessments and develop appropriate plans in relation to visiting and had not always considered the possible impact of visiting restrictions on people using the service. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency.

● The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that care and support was always provided in a person-centred manner to meet all the needs of people using the service. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure robust processes were put in place to mitigate risks related to infection prevention and control. Regulation 12 (1) (2)