Wispington House Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Wispington House is a residential care home providing personal care for up to 26 people aged 65 years and over. At the time of the inspection, the service was supporting 20 people.

The care home supports people in one adapted building. There are two floors with a stair lift installed.

People's experience of using this service and what we found
Care plans did not provide enough guidance on how to keep people safe. People were not safe in the event of an emergency evacuation. Medicines were stored safely, but 'as needed' medicines were not managed safely.

People told us they felt safe, and staff were confident in reporting any concerns about abuse. Infection control processes were not always safe, which put people at risk of COVID-19 transmission. When incidents occurred, action was taken to reduce the risk of re-occurrence.

There was not enough staff at night to meet the needs of the people safely. Staff did not have up to date training to ensure they were skilled to support people. There was a reliance on agency staff, but there were poor quality records to guide them on how to care for people safely.

People were not supported to have maximum choice and control of their lives as detailed mental capacity assessments had not been completed. People were subjected to Deprivation of Liberty safeguards (DoLs), however there was poor oversight of this. We found doors leading outside were not always locked to meet restrictions authorised in the DoLs.

Audits were of poor quality and did not produce needed improvements. There was poor management oversight to ensure risks were identified.
Complaints were recorded and responded to and the duty of candour was met. Staff, people and relatives were consulted on the running of the service and able to make suggestions.

People received enough food and drink. People were usually supported if they had swallowing difficulties. However, sometimes untrained domestic staff supported mealtimes. This risked unskilled staff not being able to respond appropriately to people's care needs. The provider has since responded to these concerns stating untrained domestic staff stopped supporting mealtimes in May 2021

We described our concerns to the provider. They created an action plan, and informed us that they intend to make the required improvements. We will assess the impact of this action plan at our next inspection.

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

Rating at last inspection
The last rating for this service was Good (published 14 September 2019).

Why we inspected
The inspection was prompted due to concerns we had received about unsafe staffing levels and an unsafe environment. A decision was made for us to inspect and examine those risks.

Due to the concerns received, we undertook a focused inspection to review the key questions of 'safe' and 'well-led'. When we arrived, we also had concerns about areas covered by the 'effective' domain. We decided to include this 'effective' domain in our inspection. 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.

We also 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.

We have found evidence that the provider needs to make improvements. We informed the provider of our most urgent concerns and they advised they would take action to mitigate these risks.

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

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wispington House 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 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 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This included a breach of regulation 12 (safe care and treatment), regulation 11 (consent), regulation 18 (staffing) and regulation 17 (good governance).

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 have requested an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 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.

Wispington House Limited

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.

An onsite inspection of the service was conducted on 10 August 2021. A further two days off-site inspection were completed on 11 August 2021 and 12 August 2021.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by two inspectors

Service and service type
Wispington House 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 did not have a manager registered with the Care Quality Commission. This means that the provider is 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 the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to

complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
During the inspection we spoke with four people and two relatives about the quality of the care provided. 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 eight care staff and the manager

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at two staff files in relation to recruitment processes. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

We then spoke to the nominated individual about our findings and to request an action plan. The nominated individual is responsible for supervising the management of the service on behalf of the provider

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 did not always have the means to seek assistance from staff. Four out of nine people visited in their bedrooms did not have their call buzzer within reaching distance. One of these people required urgent staff support and the inspector had to find staff to respond. Without the means to seek assistance, people were at risk of harm. In response to these concerns the provider promptly checked people had access to their buzzers. Additional call points were also installed within a week of the inspection to increase means to call for assistance.

● Risks to people had not been identified or addressed. For example, one person was at potential risk of falling downstairs and experiencing significant harm due to the location of their room and support needs. Effective measures were not in place to mitigate the risk of potential harm.

● Care plans were poor quality. This meant staff did not have suitable guidance to care for people safely. For example, one person's mental health had deteriorated but staff did not have guidance on how to support this person safely.

● People were not safe in the event of an emergency evacuation. People's personalised emergency evacuation plans, did not describe their diverse needs. For example, one person was known to not accept staff support. The evacuation plan did not describe what staff should do if this person was non-compliant with an evacuation. Poor guidance risks staff not supporting people safely in the event of an emergency evacuation.

● Staff were inconsistent in where people would be evacuated in the event of a fire. Some staff informed us that people would be evacuated onto the outdoor wooden decking. This decking was rotten, poorly cordoned off and had previously caused serious injury to a staff member. It was therefore not a safe place to evacuate people to during an emergency. We informed the fire service of our fire safety concerns. They visited the day after our inspection and agreed with our findings.

● The service had a 'locked door policy' as some people were not safe to go outside without supervision. However, there was an external door unlocked throughout the first inspection day. This left people at risk of harm by going outside. The provider advised they would ensure this door is locked in future.

Using medicines safely

● Some people were prescribed medicines to take 'as needed', but these medicines were not managed safely. Administration guidance for 'as needed' medicines was not always available to staff. Where it was available it did not detail crucial medical information needed to ensure medicines were given correctly. This put people at risk of potential harm from medications. The provider has stated they have responded to our concerns and have updated people's care plans to include guidance for staff with 'as needed' medicines. We will assess the effectiveness of this review at our next inspection.'

● When staff administered 'as needed' medicines, they did not always record why this medicine was given.

This poor recording means the effectiveness of the medicine could not be assessed by professionals.
● There was poor quality guidance to ensure prescribed creams were applied safely.
● Out of the five staff who administered medicines, four had out of date medicine training. There was no evidence that their skills and competency had been assessed. We were therefore concerned about staff skills to administer medicines safely.
● Medicines were stored safely, and temperature checks were completed.

People were not kept safe from harm. Risks were not assessed and mitigated, and medicines were not managed safely. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There was not enough staff deployed at night to meet people's needs. There were two staff available during the night. However, we were informed eight people required two staff for care tasks such using the toilet or being repositioned in bed. If the two staff on duty were occupied with one of these eight people, they would not be able to respond in a timely manner to the needs of other people. Staff needed to provide a quick response to other people because three people had motion sensors that required a response. Night time staffing levels did not effectively mitigate the risk of harm
● The provider had a calculator to assess the amount of staff needed at the service. However, this tool was basic and did not account for the detail described above.

We found staff were not suitably deployed at night to keep people safe from harm. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The covering manager and staff explained that the home was experiencing staffing shortages and using agency staff to support their team. The covering manager informed us they were actively recruiting new staff. We had identified that staff did not always have suitable guidance in place. There is a risk that agency staff will not know the person well, so would be heavily reliant on this limited guidance.

● Staff were safely recruited to ensure they were of good character. For example, gathering references from previous employers.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe using the service.
● Systems were in place to ensure people were safeguarded from abuse.
● Staff knew how to report abuse and felt management would listen and respond appropriately if they needed to do so.

Preventing and controlling infection
● We were not assured that the provider was admitting people safely to the service or that their policy was up to date. This is because their policy required ten days isolation for people who were new to the service. However, government guidance at the time of the inspection was for a 14-day isolation period.
● We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises. The home was generally clean. However, some areas required substantial refurbishment. For example, chairs in the lounge were worn and visibly dirty. The non-wipeable material of the chairs would prevent effective cleaning.
● We were assured that the provider was using PPE effectively and safely. We observed staff wearing suitable PPE, and people confirmed that this was usual practice.

● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
● We were assured that the provider was preventing visitors from catching and spreading infections.

Learning lessons when things go wrong
● Where incidents had occurred, these were recorded. Action was taken to review these incident records and ensure action was taken to reduce the risk of re-occurrence.
● We informed the provider about our concerns listed in this inspection report. They created an action plan and advised that improvements would be made. We will assess the effectiveness of this action plan at our next inspection.

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 deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent

Staff support: induction, training, skills and experience
- Staff training had not been kept up to date.
- Four out the five staff had out of date medicine training. We were concerned about staff's medicine management skills because we also observed that medicines were not safely managed (see 'safe' section of the report)
- Only four out of 18 staff had up to date moving and handling training. We were therefore not assured that the remaining 13 staff knew how to effectively support someone to move position.
- The service supported multiple people with mental ill health and dementia. Mental health and dementia training was not kept up to date. We also found mental health care plans did not provide enough guidance to staff. We were therefore concerned that staff may not be able to support people's mental health needs effectively
- At times, domestic staff had supported people to eat their meals. They had not received training on how to support these people's needs. This risked them not providing effective support. The provider has since told us domestic staff stopped supporting with meals in May 2021.
- Staff understood the mental capacity act but had poor knowledge of the Deprivation of Liberty Safeguards and how this would inform their practice. This means that correct Deprivation of Liberty procedures may not be met.

Staff did not have the training and skills to provide effective care. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

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, and whether any conditions

on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Mental capacity assessments and best interest decisions had not always been completed for restrictions of people's lives. This included restrictions like bed rails and motion sensors.
● One person did not agree to having personal care support and could be aggressive towards staff when it was offered. There was no mental capacity assessment or related best interests decision into the person's ability to make personal care decisions.

The Mental Capacity Act (2005) had not been followed to ensure that people could make decisions about their care. This was a breach of regulation 11 (consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care plans did not follow expected standards. For example, two people had nearly identical care plans related to skin care. Current guidance is for care plans to be person centred to meet people's individual needs. This was not person centred practice.
● The service used nationally recognised risk assessment tools like the Waterlow scoring tool. A Waterlow score identifies if a person is at risk of skin breakdown from pressure damage. We identified that one person's Waterlow score had been completed incorrectly. It identified that the person was fully mobile when they were not. Consequently, the Waterlow tool had incorrectly identified a lower risk of skin damage which put the person at risk of ineffective care.

Adapting service, design, decoration to meet people's needs
● The service was in need of refurbishment to meet people's needs. The outside wooden decking was rotten. This had caused serious injury when a staff member fell through it. However, the area was poorly cordoned off and refurbishment had not taken place to make it safe for people at the service.
● The service was in need of general refurbishment and decoration. For example, we saw exposed plaster on the walls that required smoothing and painting over. There was a general refurbishment action plan which covered only some required improvements to the home.

Supporting people to eat and drink enough to maintain a balanced diet
● Some people had difficulties with swallowing and eating. Not all staff had received training to support with this.
● People received enough food and drink. They were not at risk of malnutrition or dehydration
● People were able to choose what they ate and drank.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Referrals were made to other professionals if needed. For example, if a person became unwell then the GP was contacted. One relative told us staff were proactive at seeking involvement from external professionals.
● Where professional advice was given to staff, this was recorded and acted upon.

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 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 service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

● In February 2021, The Local Authority had completed an audit and raised concerns about the poor quality of care plans. Our inspection was six months later, and we found care plans remained of poor quality. There had been a lack of effective action to respond to this risk. This meant staff were without suitable care plan guidance for a prolonged period.
● Where care plan reviews had occurred, they were poor quality. For example, one person had repeatedly had skin damage on the same part of their body. Their care plan had been reviewed four times, but the review had not identified that this information was missing. The failure to effectively review and improve this care plan, meant staff were without sufficient guidance to provide safe care for this person.
● We identified that people had poor quality personal emergency evacuation plans (PEEPS) in place. For example, they did not fully describe people's needs or they described the incorrect bedroom that the person slept in. High quality PEEPS are needed, so staff understand how to evacuate each person in the event of an emergency. The manager advised there had been no audit or review of PEEPS. This lack of oversight prevented improvements being made.
● The service had outdoor wooden decking. This had become rotten and caused a serious injury to a staff member 11 months before our inspection. The area was poorly cordoned off and had not been refurbished. People were able to gain access to this area, and staff informed us that this decking was a possible meeting point during an emergency evacuation. The provider was aware the area was unsafe but had not arranged a timely safety improvement for the last 11 months.
● Some people at the service were not able to make decisions for themselves. Mental capacity assessments and best interests decisions had either not been completed, or they had not been completed to an expected standard. The management team did not audit mental capacity records, to ensure that people's human rights were met.
● We identified concerns with the safe management of 'as needed' medicines. These risks had not been recognised in the manager's medicine audit.
● Audits had failed to identify that staff did not always record the reason for giving 'as needed' medicine to people. The policy for 'as needed' medicine did not guide staff to follow safe standards.
● Staff training had not been kept up to date. For example, four of the five staff had out of date medicines training. The manager advised that they aimed for staff to be trained in the next six months. This is not a

timely response to risk, and puts people at ongoing risk of poor care.
● We described our concerns to the provider. They have sent us an action plan, describing improvements that they intend to make. We will assess the impact of this at our next inspection.

There was poor governance at the service. This was a breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
● Where incidents occurred, staff had contacted relevant family, stakeholders and professionals as needed.
● People told us that they had not needed to make a complaint but felt confident that any concerns would be listened to.
● The provider is legally required to notify the Care Quality Commission about events that occur at a service. These notifications had been sent as required
● There was an effective complaints process, where complaints were recorded and actioned in line with the providers policy.
● This provider is legally required to have a registered manager in position. There was no registered manager, however there was a covering manager in place that was in the process of applying to register with the Care Quality Commission

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff had team meetings and one to one supervision. Staff spoke highly of the management support.
● A relative of a person using the service praised the manager's caring nature towards their family member.
● Surveys were completed with people that used the service. These survey results recorded positive feedback.

Working in partnership with others
● The service contacted relevant healthcare professionals if needed.
●Feedback from these professionals was followed as needed.

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 11 HSCA RA Regulations 2014 Need for consent The Mental Capacity Act (2005) had not been followed to ensure that people could make decisions about their care. This was a breach of regulation 11 (consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have sent the provider a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not kept safe from harm. Risks were not assessed and mitigated, and medicines were not managed safely. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have sent the provider a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was poor governance at the service. This was a breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have sent the provider a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

There were not enough staff at night. Staff did not have the training and skills to provide effective care. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have sent the provider a warning notice.