Island Court Care Home Limited

Island Court Care Home

Inspection report

Bourne Street
Bilston
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04 August 2020
05 August 2020

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service
Island Court Care Home is a care home which provides personal care with nursing where assessed as needed to predominately older people, although it can also provide care to younger adults. The service can also accommodate people with dementia. Island Court Care Home is registered to accommodate 55 people. 35 people lived at the service when we visited.

People's experience of using this service and what we found
We found that despite regular audits taking place, some people's medication records, and care plans were not up to date or accurate. Audits completed by the provider were ineffective identifying issues we found during the inspection.

We found people were protected from potential abuse and avoidable harm by staff that had regular safeguarding training and knew about the different types of abuse.

We found there were sufficient numbers of staff members on duty to keep people safe. We found the provider followed good infection control practices. We observed staff members using protective clothing, gloves and aprons, during personal care to help prevent the spread of healthcare related infections.

Staff spoke positively about working for the provider. They felt well supported and that they could talk to management at any time, feeling confident any concerns would be acted on promptly. They felt valued and happy in their role.

Staff had received an induction that provided them with the training, information and support they required to effectively and safely meet people's needs.

Rating at last inspection:
This service was registered with us on 18/02/2020. The last rating for the service under the previous provider Indigo Care Services Limited was inadequate, published on 25/12/2019. The rating under the previous provider is carried over to the new provider.

Why we inspected
We received concerns in relation to the pre-assessment processes and medicine management of the home. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has remained inadequate.

We have found evidence that the provider needs to make improvements. Please see the safe and well led

sections of this full report.

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

Enforcement:
We have identified a breach in relation to governance at this inspection. The provider responded to the concerns on the day of the inspection.

Follow up:
We will request 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.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review.

If the service has demonstrated improvements when we inspect it again. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

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 safe.	**Good**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

Island 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
The inspection was carried out by four Inspectors. Three inspectors visited the home. One inspector reviewed documents remotely and made telephone calls to staff members and relatives.

Service and service type
Island Court Care home 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 home consists of two floors, with the residential unit based on the first floor, and the nursing unit on the ground floor.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to establish the current status of residents and staff members in relation to COVID 19. Telephone calls were made to staff members and relatives on 04 August 2020. We visited the home on 05 August 2020.

What we did before the inspection
We reviewed the records held on 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.

We also reviewed notifications received from the provider about incidents or accidents which they are required to send us by law. We sought feedback from the local authority and other professionals who work with the service. We used all this information to plan our inspection.

During the inspection
We looked at five people's care records to see how their care was planned and delivered, including pre-assessment records and risk assessments. Other records we looked at included staff training records, accident and incident records, safeguarding, complaints and compliments, staff scheduling, management of medication and the provider's audits, quality assurance, infection control procedures and overview information about the service. We spoke with four people living at the service and five relatives. We spoke with six care staff, three senior care staff, one nurse and the registered manager.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at care plans that had been updated after our visit to the care home. We also looked at, medication and quality assurance records.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this existing service under the new ownership. This key question has been rated good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from this risk of abuse

● People were protected from potential abuse and avoidable harm by staff that had regular safeguarding training and knew about the different types of abuse. One staff member told us, "Abuse can happen in different forms such as physical, emotional, neglect and financial".

● The provider had effective safeguarding systems in place and staff had a good understanding of what to do to make sure people were protected from avoidable harm or abuse. One staff member told us, "If I witnessed a resident being abused, I would take action to project them and report to my manager, the police and local safeguarding team".

● People and their relatives explained to us how the staff maintained their safety. One person told us, "I feel safe here, they look after me". A relative told us, "Since the new ownership has come in, I feel [Name of resident] is now safe".

Assessing risk, safety monitoring and management

● Risks to people's safety and wellbeing were assessed and managed. Each person's care records included risk assessments considering risks associated with the person's environment, care and treatment, medicines and any other factors.

● The risk assessments included actions for staff to take to keep people safe and reduce the risk of harm. For example, a resident who was at risk of falls had a detailed risk assessment which gave staff members instructions to ensure the person was supported when mobilising. It also contained detailed instructions in relation to bed rails management, such as staff ensuring equipment is secure, checking for no gaps or risk of entrapment before leaving the person's room.

● Staff we spoke to were aware of people's risk assessments and knowledgeable about how to keep people safe.

Staffing and recruitment

• There were sufficient numbers of staff to meet people's needs. The provider ensured people had a consistent staff team. One relative said, "I believe there are enough care staff on duty. I regularly speak to [Name of resident] and they would tell me if there was an issue with staffing".

• Each person's staffing needs were pre-assessed on an individual basis, which were reviewed and updated regularly as people's individual needs changed.

• Staff had been recruited safely. All pre-employment checks had been carried out including reference checks from previous employers and Disclosure and Barring Service (DBS) checks.

Using medicines safely

• Medicines were managed to ensure people received them safely and in accordance with their health needs

and the prescriber's instructions.
• Staff completed training to administer medicines and their competency was checked regularly to ensure safe practice.
• Administration of medication records indicated people received their medicines regularly. This was confirmed by the people we spoke with.
• Some people had been prescribed medicine to be used as required (PRN). There were clear protocols for staff to follow before administering these.
• People's medicines were safely received, stored and administered. Management completed monthly audits of medicines to ensure policies and procedures were followed and any errors or concerns were identified. We saw in these audits that where issues were identified appropriate action was taken, including learning opportunities for staff.
• We found stock levels were not in line with medication records and this was discussed with the registered manager during the inspection. We found this had no impact on people however it demonstrated that audits completed were ineffective.

Preventing and controlling infection
• Staff had completed infection control training and followed good infection control practices. They used protective clothing, gloves and aprons, during personal care to help prevent the spread of healthcare related infections.
• People told us staff practiced good infection control measures. People were protected from cross infection. The service was clean and odour free.

Learning lessons when things go wrong
● Records showed that incidents and accidents were monitored and analysed so that changes could be made to reduce the risk of further harm.

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.

This is the first inspection of this existing service under the new ownership. This key question has been rated 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

• Systems were not effective for monitoring the quality and safety of the services provided. Medication and care plan audits completed by the provider had not identified issues found during the inspection. For example, one person's care plan stated staff should assist the person to reposition every two hours. The records we checked provided no evidence this was taking place. When we spoke to the registered manager, they informed us that the resident could reposition themselves however this was not reflected in the person's care plan.

• Medication stock for controlled drugs were not in line with MAR charts and audits. As a result, during the inspection 10 mil of a controlled drug was identified as missing. After the site visit, the registered manager sent us evidence confirming the 10 mil had been destroyed due to being out of date and this was recorded in the destruction book. The MAR chart and medication audit documents should have been updated to reflect the destruction taken place. In addition, we found three prescribed medication tablets were missing, the registered manager was unable to provide us with evidence regarding what had happened to these tablets.

• A person had their medication administered covertly in a drink supplement. During the inspection we found no recorded evidence that a discussion was made with the GP or pharmacy to establish if administering the medication is this manner could compromise the medication. After the inspection the registered manager contacted the GP and pharmacy and sent us evidence of the discussions taking place.

• Systems to monitor the service had not identified issues we found during the inspection. For example, two residents had recorded high blood sugars levels in comparison to their usual levels. we found no recorded evidence of any discussion or action taken to address these high levels. High blood sugar levels can potentially have a detrimental impact on a person's health; therefore action should be taken to monitor and address high levels. The registered manager confirmed that she would speak to all staff members and ensure they would record actions taken.

• Systems to monitor the service had not identified that some care plans were not up to date. For example, one resident was diagnosed with a health care condition however we found no mention of this in the person's care plan. As a result, there were no recorded instructions for staff members to follow in relation to the management the health care condition and actions to take if the person had a seizure. Staff members we spoke to were aware of the person's health care condition diagnosis however new staff members or agency staff members would be at risk of not being aware due to no mention of this in the person's care plan. After the inspection the registered manager sent us an updated care plan containing relevant details about how staff should support the person with the health care condition.

The lack of governance systems and oversight meant people were at risk of receiving poor quality care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People, relatives and staff expressed confidence in the management team and had noticed a positive change since the change of ownership.
One relative told us, "If you had contacted me back in August, I would be giving you totally different response. Things are such much better since the new owners took over, the management of the home is much better now".
• People and relatives told us there was a positive and open atmosphere. A relative told us, "Yes the atmosphere is friendly, and the management are approachable."

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 registered manager was aware of the legal responsibility to notify us of incidents that occurred at the service.
• The registered manager told us if mistakes are made they took full responsibility to ensure that the same mistake were not repeated. The information was used as a learning opportunity and to improve the service.
• Staff were actively encouraged by the registered manager to raise any concerns in confidence one staff member told us, "I would have no issue raising any concerns."
• The provider had a whistle blowing policy and staff understood their responsibilities to raise concerns where people are put at risk of harm.

Engaging and involving people using the service, the public and staff.
• Staff reported positively about working for the service and did not identify any areas for improvement.
• People were positive about resident meetings they had attended.
• The registered manager consulted with staff at meetings, to get their views and ideas on how the service could be improved.
• People and relatives told us they were happy that the service had listened to them and recently had refurbished the home.
• There was an open culture where staff were encouraged to make suggestions about how improvements could be made to the quality of care and support offered to people. One staff member told us that they had made suggestions to management and these had been implemented. They told us, "Prior to lockdown I suggested we would take residents who were able to do more activities outside of the home. As a result, we took some people to the local museum and pub".
• A relative we spoke with told us as they were unable to go into the home during lockdown. They were able to visit once per week by arranging the time of the visit with the home then and being able to speak to their relative via a window in the garden. This enabled them to safely see and speak to their relative during the COVID19 pandemic.

Continuous learning and improving care.
• The provider and registered manager used a quality assurance audit system to monitor the quality of the service and this information was shared with staff.
• The registered manager provided regular learning opportunities for staff.

Working in partnership with others
• The registered manager and provider had engaged on a regular basis with the local authority during the

COVID19 pandemic. This evidenced partnership working between the home and external professionals to enable positive outcomes for people.

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 17 HSCA RA Regulations 2014 Good governance Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; The lack of governance systems and oversight meant people were at risk of receiving poor quality care. Systems were not effective for monitoring the quality and safety of the services provided.