Wings Care (North West) LLP

Oak Cottage

Inspection report

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Date of inspection visit:
14 December 2023
19 December 2023
22 December 2023

Date of publication:
29 February 2024

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Oak Cottage provides accommodation and personal care for a maximum of seven people with complex needs. The accommodation consists of six self-contained flats with a shared kitchen and lounge and a separate self-contained apartment to the rear of the main building.

People's experience of using this service and what we found

Right Care
People's needs and risks were not adequately assessed or managed to mitigate the risk of avoidable harm. Staff lacked clear information about people's needs and risks. Some of the support provided was not always well planned to ensure that people's emotional wellbeing was supported appropriately.

Medication management was unsafe. There were no effective systems in place to account for medicines administered to people. This meant it was impossible to tell if the balance of medicines in the home was correct and people had been given the medicines they needed. Medicines were not always stored at a safe temperature and there was a lack of safety checks around the competency of staff to administer injectable medicines.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. People's consent was not sought in line with the principles of the Mental Capacity Act 2005.

The checks in place to prevent legionella bacteria developing in the home's water supply were not completed properly to mitigate risks. Other aspects of maintenance were also not completed in a timely manner. A smoking shelter situated in the garden area was in poor repair and not fit for purpose.

Accident, incidents and safeguarding events were recorded and reported. However safeguarding risks were not always safely assessed or managed. Sometimes the response to people's emotional distress was not carried out in such a way as to de-escalate distress and any impact on the person's mental wellbeing.

Improvements were needed with regards to the recruitment of staff. Agency and bank staff covered gaps in the rota but not some did not have staff profiles in place to show what training, skills and competencies they had.

Right Support
Everyone living in the home was funded for a certain amount of one to one support hours, but the system in place for to monitor how this was delivered was unclear.
The home was satisfactorily clean, and people were supported with daily living tasks as required. People told us they liked living in the home and that staff supported them. One person told us "Staff are good, firm

but fair". A relative told us the staff were kind and that they communicated with them well.

Staff spoke warmly about the people they supported and had a good understanding of the social activities people liked to do and how people liked to spend their time. During our inspection we saw that people were supported to access activities in the community and do the things they enjoyed. This helped reduce social isolation. People were supported to maintain good family relationships and relatives visited the home without restriction. This was good practice.

Right Culture
The systems in place to assess the quality and safety of the service including service culture were not robust. They had not identified most of the concerns we found during the inspection. Managerial oversight by the manager and the provider was ineffective. This placed people at risk of avoidable harm as risks to their health, safety and welfare were not safely managed.

The culture of the home was for the most part relaxed but there were aspects of service culture that were appeared institutional. There were certain routines and language used by staff that appeared restrictive. Changes to people care were not always adequately planned for to mitigate the impact on people's wellbeing and to ensure positive outcomes were achieved. We spoke with the manager and nominated individual about this.

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

Rating at last inspection and update)
The last rating for this service was good (published August 2017. At this inspection, we found that the quality and safety of the service had significantly declined. Breaches of the regulations were found, resulting in a rating of inadequate for both safe and well-led. At this inspection, breaches of regulations 11 (Need for Consent); 12 (safe care and treatment); 17 (Good governance) were identified.

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

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

Why we inspected
The inspection was prompted in part due to concerns received regarding the quality of care. A decision was made for us to inspect and examine those risks and review the previous rating. 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. 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.

Enforcement
We have identified breaches in relation to the safety of people's care, the implementation of the mental capacity act, deprivation of liberty safeguards and the management and governance 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
We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.	**Inadequate**
Is the service well-led? The service was not well led.	**Requires Improvement**

Oak Cottage

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.

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 undertaken by an adult social care inspector.

Service and service type
Oak Cottage 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 CQC 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 a registered manager in post.

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. 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
We spoke with the registered manager, senior care assistant and 2 support workers. We spoke with 2 people who lived in the home and a relative about their experience of the care provided. We reviewed a range of records. This included 3 people's care records and medication records. We looked at records in relation to safe recruitment and a variety of records relating to the management of the service.

After the inspection visit.
We continued to seek clarification from the provider to validate evidence. We continue to review evidence in relation to people's care, and the management of the service. We discussed our concerns about the service with both the registered manager and the nominated individual for the service (who has responsibility for supervising the regulated activity).

Inadequate

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 good. At this inspection, the rating for this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- Medicines were not managed safely. There was no robust system in place to account for medicines. This meant it was impossible to tell if the stock of medicines in the home was correct and in accordance with what should have been administered.
- People's medication charts were pre-typed with set times of administration each day. These records did not always match with information recorded in people's daily records at to when medicines were given, and some medicines had not been recorded as given at all. Not ensuring medicine administration is accurately recorded places people at risk of missing vital doses of their medication or receiving too much medicine in a specified timeframe.
- Some people were unable to have their 'as and when' required medicines at night because staff on duty, were not trained or assessed as competent in administering medicines. This meant people were placed at risk of unnecessary distress or discomfort.
- There was a lack of evidence pertaining to the training and competency of staff to administer injectable medicines and the authorisation to do so from a medical professional.

The management of medication was unsafe. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- People's needs and risks were not adequately assessed, and staff lacked guidance on how to support people's physical and mental health needs appropriately.
- Information on the strategies used to keep people safe and well were not clear, and in some cases not properly understood.
- Changes in some people's care such as moving to or aiming to move to new accommodation were not appropriately risk assessed or planned to mitigate the impact of these changes on people's emotional and physical wellbeing.
- People lived in their own apartments with a fitted kitchen which included an electric oven and other domestic appliances. Despite this, no adequate assessment of each person's domestic living skills had been completed to ensure they were safe and competent to use this equipment unsupervised. This placed people at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Some people had complex mental health needs that caused significant distress. People were not always supported in a positive way or in a way that prevented their distress from escalating placing them and others at risk.

Risks to people's health, safety and welfare were not adequately assessed, and mitigated against to prevent avoidable harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was a system in place to record and report accident, incidents and safeguarding events within the service and these were reviewed to learn from.
● People told us they felt safe living in the home and with the staff team that supported them.

Preventing and controlling infection
● We were not assured that the provider was mitigating the risk of Legionella bacteria from developing in the home's water system. The safe checks identified in the provider's Legionella risk assessment had not been properly carried out or monitored to mitigate the risk of harm.

The provider had not ensured the risk of Legionella infection was effectively managed. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Records showed the temperature of the water in some people's individual bathrooms was not hot enough to promote and encourage good personal hygiene.
● The home's environment was satisfactorily clean and people were prompted and supported to keep their own apartments clean and tidy.

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.

● When there were concerns about a person's capacity to consent to a specific decision, mental capacity assessments had not always been undertaken. Best interest decisions had also not been made with involvement of relevant people. For example, decisions relating to people's financial allowance and deprivation of liberty safeguards.
● Some people's DoLS conditions put in place to keep them safe, were not adhered to. Providers have an obligation to comply with any conditions attached to a DoLS authorisation. A failure to do so places the person at risk of not receiving the right level of supervision to keep them free from avoidable harm.

People's legal right to consent to and make decisions about their care and treatment had not been supported in line with the MCA. Deprivation of liberty safeguards were not always respected. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Agency and bank staff were regularly used to fill gaps in the rota. Not all of the agency staff had staff profiles in place for the manager and provider to be assured of their suitability.
- The system to monitor the one to one support people needed and received was unclear and the documentation provided in relation to this did not make sense.
- The number of staff in the home to support people in communal areas was sufficient during the inspection.

We recommend the provider reviews the information it holds on agency staff to ensure it provides assurances that agency staff are suitable to work in the home. We recommend the provider reviews the tracking system in place to plan and monitor people's one to one support to ensure it is effective.

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 good. The rating for this key question has 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

- The systems in place to monitor the quality and safety of the service were not effective. For example, care plan audits had not identified failings in the assessment and planning of people's care or that some people had not had access to regular meetings with their assigned keyworker. Medication audits had not identified the failings in safe medicine management and health and safety audits had not identified the shortfalls in Legionella monitoring. This lack of robust governance placed people at significant risk of avoidable harm.
- Provider and managerial oversight of the service was insufficient. We were not assured the provider fully understood their regulatory requirements or their responsibility to ensure robust systems were in place to mitigate risks to people's health, safety and welfare.
- The way in which people's support was planned and delivered did not always promote good outcomes for people. People's emotional needs were not always supported appropriately or in accordance with the Mental Capacity Act and there was a lack of transitional planning for changes in people's care to prevent any negative emotional impact.
- Some of the language used by staff in people's daily records and some of the home's rules suggested an authoritarian approach to some aspects of care. We spoke with the manager and nominated individual about this.

The governance arrangements were not robust. Managerial and provider oversight was poor and service delivery did not always promote good outcomes for people. This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Continuous learning and improving care; 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 and provider had notified CQC about notifiable events with regards to people's care. Providers are required by law to submit the required notifications to CQC without delay. The information provided in notifications helps CQC to decide if further action is needed to ensure people's safety.
- There were systems in place to record accidents and incidents including safeguarding events and to learn from them. Multi-agency meetings took place to discuss people's needs, care and support. People's care plans however did not always include details of when these multi-agency meetings took place and their outcome.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People living in the home and their relatives were engaged and involved in the day to day delivery of the service and people were asked for feedback on the support they received.

● Staff told us they enjoyed working in the home and felt supported by the manager and provider.

● The manager and staff at the home worked in partnership with a range of other health and social care professionals including GP's, specialist learning disability nurses, other medical professionals including mental health teams, DoLs Assessors and Advocates.

● People were supported to do the things that they enjoyed and accessed the community regularly to prevent social isolation. People were supported to maintain positive family relationships and family members visited without restriction. This was good practice.

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 11 HSCA RA Regulations 2014 Need for consent People's legal right to consent to and make decisions about their care and treatment had not been supported in line with the MCA. Deprivation of liberty safeguards were not always respected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The governance arrangements in place were not robust. Managerial and provider oversight was poor and service delivery did not always promote good outcomes for people.

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 The management of medication was unsafe. Risks to people's health, safety and welfare were not adequately assessed, and mitigated against to prevent avoidable harm. The provider had not ensured the risk of Legionella infection was effectively managed.

The enforcement action we took:

We have issued the provider with a warning notice. This will be followed up and we will report on any action when it is complete.