

Mi Care Wicksteed Court Ltd

Wicksteed 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 responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Wicksteed Court Care Home is a residential care home providing accommodation and personal care for up to twenty-five people. At the time of inspection there were eighteen people living at the home.

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

Person centred care was impacted by limited opportunities for people to engage in, and to be supported, to follow their interests or take part in activities. Staff who were responsible for providing activities told us, there were not enough staff, or they did not have sufficient time as they had to fulfil their primary responsibility of providing personal care.

Staff shortages, for example due to staff absence meant the provider routinely used agency staff to ensure there were enough staff to keep people safe. We identified missing or incorrect information on the electronic medicine system. The registered manager submitted information following our visit to evidence the necessary changes had been made.

Improvements were needed to support decisions made to keep people safe were in their best interests. For example, best interests' decisions had not been documented to support the use of equipment to promote people's safety, which also had the potential to restrict people's independence and freedom of movement. Mental capacity assessments had been carried out where it was thought people lacked capacity to make informed decisions about their care.

People living with dementia could potentially benefit to improvements within the service to support them in navigating around the service. For example, increased signage and the use of memory boxes. A programme of ongoing decoration and improvement to the service was in place.

Mixed feedback was received from staff about the management and leadership of the service, and whether staff worked well as a team to deliver good outcomes for people.

Systems and processes were in place to assess and reduce potential risk to people. People's records provided key information for staff to support them in promoting people's safety. Staff recruitment processes were robust, and staff undertook training in safety related topics. Infection control and prevention guidance had been implemented consistent with government guidance related to COVID-19.

People's needs were assessed and kept under review. People were supported by staff who had the necessary skills, knowledge and experience, who were supported through ongoing supervision and monitoring. People's health and welfare was promoted and supported by health care professionals where required. People's care plans provided limited information as to their wishes on end of life care. People's care plans provided clear information about their needs and were regularly reviewed, which included information as to people's communication needs.

Systems and processes for quality monitoring were in place, which included a daily report being submitted by registered manager to the provider. A regular schedule of audits took place. Information was shared with staff through regular staff meetings. People's views and that of their family members were sought annually through questionnaires.

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 Requires Improvement (published 29 April 2021) 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.

Why we inspected

We inspected in response to receiving information of concern with regards to people's safety, staffing numbers and the quality of care provided, and to follow up on the issues identified in previous inspections. As a result, we undertook a focused inspection to review the key questions of Safe, Effective, Responsive and Well-led. We have found evidence that the provider needs to make improvement.

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.

We reviewed the information we held about the service. No areas of concern were identified in the other key question. We therefore did not inspect Caring. 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 the same.

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 a breach of regulation. We found people had limited opportunities to take part in regular and scheduled recreational events and activities, which were organised and facilitated by sufficient staff to encourage and support people's participation.

Please see the action we have told the provider to take at the end of this report.

We will request an action plan for 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?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Wicksteed 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 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 carried out by two inspectors.

Service and service type

Wicksteed 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 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

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. 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.

During the inspection

We spoke with two people who used the service and four relatives about their experience of the care provided. We spoke with eight members including the registered manager, senior carer, carers and housekeepers.

We reviewed a range of records. This included three people's care records and three medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the maintenance of the property and environment were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We spoke with two care staff by telephone on 20 October 2021. We looked at training data, staff meeting minutes and quality assurance records and data.



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 Requires Improvement. At this inspection this key question has remained the same. 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

Staffing and recruitment

At the last inspection the provider had failed to ensure there were sufficient staff deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement has been made at this inspection and the provider was no longer in breach of regulation 18.

- A person told us there were not enough staff to support them, which meant they experienced discomfort. They told us, "Call bells take a long time (to be answered). Everything comes down to they haven't got enough staff." Our observations were that call bells were answered promptly.
- Staff views about whether there were enough staff to meet people's needs and keep them safe were mixed. A staff member said, "There is enough staff when things are running smoothly." Another staff member said, "There is enough staff if you have a good strong team. That doesn't happen often. But otherwise it is hard."
- On the day of the inspection a staff member had informed the registered manager they would be absent due to ill health. The registered manager had contacted an agency. However, the agency had no staff available at short notice. The staff rota showed agency staff were used to support staff shortfalls.
- The registered manager informed us they were actively advertising for staff.
- The registered manager continued to use a dependency tool, which assessed the needs of people, and determined the number of staffing hours required. Staffing numbers had increased in response to an increased number of people using the service.
- Staff recruitment practices were robust. Staff records included all required information, to evidence their suitability to work with people, which included a Disclosure and Barring Service check (DBS). The DBS assists employers to make safe recruitment decisions by ensuring the suitability of individuals to care for people.

Using medicines safely

- Improvements were needed to ensure the electronic medication system contained the correct information. For example, some medications prescribed to be given routinely were recorded as to be given as and when required. This meant the provider could not be confident medication was being administered as per the prescriber's instructions. The registered manager informed us a senior member of staff was aware of the issues, and was in the process of updating the system. The registered manager submitted information following our site visit showing the errors on the system had been rectified.

- The previous inspection found there were no PRN protocols (medication to be given as and when required) in place for medication to be given as and when required. We found improvements still needed to be made as there continued to be some missing protocols for a person recently admitted to the service. The registered manager was not aware of the protocols not being in place, they submitted the medicine protocols following our site visit.
- People's records contained information about their prescribed medication and how they preferred to take their medication.
- Mental capacity assessments were undertaken where it was believed people lacked capacity to make an informed decision to refuse to take their medication. Where people were found not to have capacity to make an informed choice, then best interests decisions to administer medication covertly (disguised in food or drink) were made involving health care professionals and family members.
- Staff who administered medication undertook medicines training, and had their competency checked by the registered manager.

Systems and processes to safeguard people from the risk of abuse

- The registered manager had reported safeguarding concerns and liaised with relevant agencies in line with local safeguarding protocols. Records of referrals, their progress, investigation and outcome were monitored, with records kept.
- People's safety was monitored and promoted. Staff had been trained in safeguarding procedures and knew what action to take to protect people from harm and abuse. This included knowledge in who to report concerns to, both internally and to external agencies.

Assessing risk, safety monitoring and management

- Potential risks to people's safety were assessed and regularly reviewed. These included health and medical needs, risk of falling, food and fluid intake, moving and handling, and skin integrity.
- Equipment was used to promote people's independence and safety. For example, moving and handling equipment. Where people required a walking frame, we noted these were placed next to them to promote both independence and safety.
- People's records were electronically stored. Staff had access to handheld devices, giving them access to people's care records. Staff recorded all care interactions electronically.
- Personal emergency evacuation plans were in place to ensure people were fully supported in the event the service had to be evacuated.
- People's safety was promoted through the monitoring and maintenance of the environment, which included fire, gas and electrical systems by external contractors.

Preventing and controlling infection

- 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 promoting safety through the layout and hygiene practices of the premises.
- 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.
- We were assured the provider was facilitating visits for people living in the home in accordance with the

current guidance.

Learning lessons when things go wrong

- Staff confirmed they completed incident forms when an incident or accident occurred. A staff member told us, "We complete an electronic accident form, inform relatives and the registered manager."
- A monthly analysis of accidents and incidents in the service was carried out by the registered manager to identify and themes or trends. The analysis documented measures to reduce future risks to people.

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 Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

A previous inspection, for which the report was published in May 2020 found the provider had failed to ensure people received care that met their needs and preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvements had been made. The provider had met elements of the breach of regulation 9.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- At the last inspection we found people's records provided inconsistent or incomplete information about dietary needs and oral health care, we found improvements had been made. People's oral health care and dietary needs were assessed, and information as to how these were to be met were recorded within their records.
- People's needs were assessed prior to their moving into the service. Assessments included information from health and social care professionals, and information requested by the registered manager through documentation or discussion, with the person and family members.
- Assessments considered the use of equipment to maintain people's independence. For example, walking frames were placed close to people, enabling them to move independently around the service.

Adapting service, design, decoration to meet people's needs

- Improvements and adaptations to the environment could improve people's sense of well-being and purpose. We shared with the registered manager areas for their consideration. For example, displaying photographs of the local area in which people previously lived and the use of equipment to provide people with a sense of purpose by engaging in meaningful activities.
- People could be further supported to orient themselves by the use of personalised information. For example, photos or memory boxes by their bedroom door. Signage was displayed to support people with recognising key rooms. For example, the bathroom, toilet and communal rooms. A large interactive noughts and crosses board was displayed on the wall in the dining room.
- The registered manager told us people and their family members were encouraged to personalise their bedrooms, for example with photographs.
- A planned programme of decoration was in place and ongoing, which included the decoration of corridors, and the replacement of carpets on stairwells which were scheduled to be undertaken the week following our inspection.

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 were undertaken where it was believed people lacked capacity to make an informed decision for the use of bed rails to prevent their falling out of bed. However, these were not supported by best interests' decisions where equipment was used to promote people's safety, which when used placed restrictions on people's freedom. For example, the use of bed rails to prevent people injuring themselves by falling out of bed. The registered manager said they would act and complete best interests' decisions.
- Mental capacity assessments were undertaken where it was believed people lacked capacity to make an informed decision to refuse to take their medication. Where people were found not to have capacity to make an informed choice, then best interests decisions to administer medication covertly (disguised in food or drink) were made involving health care professionals and family members.
- The registered manager had submitted applications (DoLS) to the relevant bodies as required by the MCA.

Staff support: induction, training, skills and experience

- Staff undertook a period of induction when they started working at the service, which included working alongside experienced staff. Training was provided to equip staff with the skills and knowledge to meet people's needs, promoting their health, safety and welfare. A member of staff who had recently been employed told us their induction was informative and had included working alongside experienced staff and being shown key aspects of safety. For example, how to respond to a fire alarm.
- Staff were regularly supervised by the registered manager, which included one to one meetings and observed practice.

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

- People's nutritional needs were assessed and regularly reviewed. Individual dietary needs were catered for, which included diets to support people living with diabetes or lactose intolerance and soft diets to make swallowing easier.
- People were relaxed during the lunchtime meal and were not rushed, and music played quietly in the background.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Staff recorded their observations of people's day to day health and well-being. Referrals were made to the appropriate relevant healthcare professional when required. For example, to a GP, district nurse or speech and language therapist.
- The registered manager advised GP consultations were held over the telephone since the COVID pandemic. A nurse practitioner visited the service regularly to provide healthcare support and guidance to

people, and staff.

- A visiting health care professional told us they had no concerns about the care people received, and that communication between staff and themselves was good, with staff acting upon any health advice given to promote people's health and well-being.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

A previous inspection, for which the report was published in May 2020 found the provider had failed to ensure people received care that met their needs and preferences. This was a breach of regulation 9 (Person centred care) 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 9.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them;

- At a previous inspection people told us there were limited opportunities for them to take part in activities. We found improvements were still needed.
- We asked people about activities, a person told us, "They had someone in last week singing. They forgot about me, I wanted to go, but they forgot to come and get me. I've got no one to talk too. I am in this room all the time. If I could just get some company."
- Staff were responsible for organising and providing day to day activities. Staff consistently said there was insufficient time, or staffing resources available. Staff said, when they did initiate activities, they were often interrupted as they were needed to provide personal care.
- A member of staff told us, "Not many activities going on. Chucking a ball. It is heart-breaking seeing people staring at four walls with nothing to do." A second staff member said, "No activities, we will do some stuff in the afternoon if we have time."
- We saw that most people spent a majority of their day in the lounge, the activity listed for the day was 'Classic FM'. We saw people sat around the perimeter of the lounge; the television was on with subtitles. However, few people were watching the television, and sat with their eyes closed, or looking around the room. Interactions between people and staff were limited to when personal care and support was provided.

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

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- At a previous inspection people told us their day to day choices were not always supported, people did not express concerns about their choices at this inspection
- Staff told us some people preferred to have personal care delivered by female staff. However, on occasions there were two male staff on during the night. We spoke with the registered manager who said this had happened on a few occasions due to staff shortages and having to use agency staff.

- People's care records provided information detailing their physical care needs, and the role of staff in promoting people's health and welfare. People's views, and that of family members had been sought, and were reflected within people's records.

End of life care and support

- People's records provided limited information as to people's wishes with regards to end of life care. The registered manager told us that in their experience, people's and their family members found it a difficult topic to talk about and share their views, however people were encouraged to do so.
- Staff had received training on end of life care.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were documented within their records, which included any support they needed. For example, hearing aids or spectacles to promote good communication, and we saw people wore spectacles where required.

Improving care quality in response to complaints or concerns

- The provider had a complaints policy and procedure. The registered manager said they had not received any complaints or concerns since the previous inspection.

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 Requires Improvement. At this inspection this key question has remained the same. 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

- The provider had failed to make sufficient improvements identified at a previous inspection. For example, there were insufficient opportunities and resources, including staff, to enable people to engage routinely in scheduled activities and recreational events.
- Some staff spoke of low morale amongst the staff team due to not feeling appreciated or valued, staffing levels and the lack of activities available for people. Other staff spoke of recent improvements within the culture of the service and spoke of staff being more supportive of each other and working as a team to achieve better outcomes for people.
- Some staff spoke of poor communication, leadership and co-ordination amongst the staff team, which impacted on their ability to provide care well. A staff member told us, "Lack of communication....sometimes you are supporting people and you look around and you think, 'where are the others? [staff]'. Another staff member said, "Team dynamics don't help. Difficult to explain, some staff stick together."
- Staff views were mixed as to whether the registered manager was approachable, and whether they effectively dealt with staff concerns and issues raised. A staff member told us, "[registered manager] sits in the office, isn't interested." Another staff member said, [registered manager] is nice, looks out for us. You can go to her and she will deal with it."
- Staff who had recently started working at the service spoke of the support they had received from the registered manager and the staff team. They told us staff were welcoming, and made them feel part of the staff team.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Staff meetings were held monthly, and minutes showed staff were kept informed of key issues, including any changes required to bring about improvement. For example, staff were provided up to date information on visiting guidance in response to COVID-19, updates on training, promotion of good practice such as infection control, and discussions to refresh staff knowledge.
- The registered manager understood their role and responsibilities and was supported by senior carers. The registered manager or a senior carer undertook twice daily walkarounds of the service to observe staff interactions with people, talk with people and staff, and to undertake visual checks on the environment and to identify any potential safety concerns. A staff member told us they had been questioned by the registered manager as to their actions during a walkaround, they told us they viewed this as the registered manager

being supportive, and promoting good quality 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 registered manager understood their role and responsibilities, and a policy and procedure detailed how the provider would meet its obligations under the duty of candour. No incidents had met this criterion. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support, and providing truthful information and a written apology.
- Notifiable incidents were reported by the registered manager to the Care Quality Commission (CQC) and other agencies.

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

- People's views and that of their family members were sought annually through questionnaires. The results of the most recent survey of 2020 were displayed on the wall of the dining area, represented with pie charts, and included additional comments made. The registered manager said they were in the process of preparing questionnaires to be sent out for this year's annual quality check.
- Family members involvement with people's care was documented within people's records. Visitors we spoke with told us they were kept informed about key issues affecting their relatives care. A visitor told us there had no concerns, and spoke of communication having always been fine, and believe their relative was looked after well."
- Compliments and thank you cards had been received from family members about their relative's care.

Continuous learning and improving care

- The registered manager implemented the provider's systems and processes to monitor the quality of the service, which included routine auditing and analysis. For example, safeguarding concerns, accidents and incidents were reviewed monthly and any themes or trends identified.
- The registered manager submitted a daily report to the nominated individual, (nominated individual is responsible for supervising the management of the service on behalf of the provider) providing an overview of key areas of the service. For example, the outcome of their daily walk arounds, a summary of visitors to the service, staffing and the outcome of quality audits and monitoring.

Working in partnership with others

- Staff worked with other health and social care professionals to promote people's health and welfare.
- The management team had kept in contact, sharing information with external agencies including the local authority and family members throughout the COVID-19 pandemic.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The provider had failed to meet people's needs and preferences. There were insufficient opportunities available to people to ensure activities were routinely scheduled with sufficient resources, including staffing, to support people's participation.</p>