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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

Wicksteed Court Care Home is a residential care home providing accommodation and personal care for up to 25 people. At the time of inspection there were nine people living at the home.

People's experience of using this service and what we found
This inspection was focussed on the concerns that had been passed to us around people's safety.

Quality assurance systems were not detailed enough to reveal shortfalls in the risk assessments around people's care. These contained details of more than one person and therefore were not personalised.

Improvements continue to be made to the premises, and risk assessments had been completed and were regularly reviewed to help reduce the risks known to people. People had Personal Emergency Evacuation Plans (PEEPS) in place which reflected their current needs to ensure their safe evacuation in the event of an emergency.

Audits were in place for people's care plans and care plans were regularly reviewed, and this reflected people's care needs. Falls, accidents and incidents were reviewed, and any lessons learnt were communicated to staff to reduce the likelihood of further incidents. Staff supervisions continue to be completed and now include direct supervision by the registered manager on staff performing caring tasks and medicine administration.

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

Rating at last inspection and update
At our last inspection the service was rated Inadequate (published 11 May 2020) and there were multiple breaches of the regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found some improvements had been made. However, the provider was still in breach of the regulations.

This service has been in Special Measures since 11 May 2020. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We inspected to follow up on the issues identified in the previous inspections and to see if improvements had been made to these areas.

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 coronavirus and other infection outbreaks effectively.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wicksteed Court Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified a continued breach in relation to staffing numbers at this inspection.

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

Follow up
We will continue to monitor information we receive about the service until we 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?

Requires Improvement

The service was not always safe.

Details are in our findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our findings below.

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. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.

The service had a manager registered with the Care Quality Commission. Registered managers and providers have legal responsibilities for how they run the service and for the quality and safety of the care provided.

Notice of inspection
Due to COVID-19, we telephoned the service immediately before we entered the home. This was to enable us to ensure we had appropriate personal protective equipment for the inspection.

What we did before the inspection
We reviewed the information we had about this service which included safeguarding information and statutory notifications the service had submitted. We used all this information to plan our inspection.

We did not ask the provider to complete a Provider Information Return prior to this inspection as this was a targeted inspection. This is information we require providers to send us annually following their first inspection to give us 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 to four people who lived at the home, seven members of staff and the registered manager. We examined the premises and reviewed the quality assurance systems that had been put in place. We looked at three people's care plans and reviewed three staff recruitment files.

After the inspection
We spoke with three relatives of people who live at the home. We also received a number of documents from the registered manager.

Requires Improvement

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 rating inspection in February 2020 we rated this key question inadequate. We returned in August 2020 to ensure improvements had been made, at this time the service was 'inspected but not rated'. At this inspection this key question has improved to Requires Improvement. 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.

At our inspection of February 2020 the provider had failed to ensure there were enough numbers of staff deployed to meet people's needs. The provider failed to provide the training and support required to enable staff to carry out their roles. These were a breach of regulation 18 Staffing 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 18.

Staffing and recruitment

●Though the service uses a recognised staff dependency tool to calculate staffing numbers. We found occasions when there were insufficient staff to meet the needs of people who lived in the home.

● Staff told us that at times they were very stretched assisting people with multiple and complex needs. We saw people were calm and engaged in the morning. However, by mid-afternoon staff were visibly busier and found it difficult to deal with all the needs people displayed. One member of staff said, "If people are unsettled it is very hard, sometimes I am running from one person to another, I do my best." Another said, "Some days there is enough staff, it depends on the mood of the residents. Some days it is so busy, after 2.00pm or 2.30pm when people are on the move." Another said, "We need to spend more time interacting with people. I think people need more stimulation."

● We noted from the training records that not all staff were trained in courses that would benefit people who lived in the home and guide staff's self-protection.

● We received mixed feedback about training. Some staff felt more face to face training would be beneficial for their development. Staff told us they completed some online training at home in their own time. Due to the pandemic, opportunities for training in person have been limited over the last year.

We found no evidence that people had been harmed however, staffing deployment and training was not effectively managed. This placed people at risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider recruited staff in a safe manner. This meant that checks were carried out before employment to make sure staff had the right character and experience for the role.

Assessing risk, safety monitoring and management

● The registered manager had introduced an electronic care planning and risk assessment system. Care plans and risk assessments were detailed and readily available for staff to access, read, and update when required. However, we found in two of the three people's risk assessments we looked at the names in the body of the text differed from the person whose plan it was.
● Risk assessments documented any potential risks that may cause avoidable harm. These included health and medical needs, as well as assessed risks of falls, moving and handling, and food and fluid intake.
● Risks were regularly reviewed, and staff understood and followed risk assessments appropriately. Staff told us, and records confirmed, people were repositioned regularly in a timely manner when required and moving and handling practices were safe using the correct equipment where needed.

Using medicines safely
● The temperature in the medicines room was not always within the range specified in the medicine guidance folder. For example, the temperature was too high in all recordings between the morning of 2nd March to the afternoon of 6th March. There were gaps in the recording of temperatures so we could not be assured medicines were always stored safely.
● There were no protocols in place to give staff guidance on when to administer medicines prescribed as and when needed (PRN). These were put in place immediately when brought to the attention of the registered manager.
● Medicines were administered safely using an electronic system. We checked medicine administration records (MAR) and found they were being used correctly. People received their medicines in the way they preferred. One person told us, "I take three pills, they are always on time. They set them here (pointed to jumper) then I take them, that's how I like it."
● Staff administered people's medicines in line with the provider's policies and procedures. This included when GP authorisation had been given for medicines to be administered covertly without a person's knowledge.
● Staff received regular training and competency checks on the medicine administering process.

Systems and processes to safeguard people from the risk of abuse
● People were safe. People we spoke with indicated they were safe within the home and with the staff group. Observations we completed demonstrated people were relaxed with the staff group and responded to them positively. People's relatives we spoke with felt their relation was safe within the home.
● Most staff were trained in how to keep people safe from abuse and recognised the signs that might indicate a person was being abused. Staff we spoke with knew how to report concerns to the registered manager and were confident to do so if required.
● Systems were in place to ensure people were safeguarded from abuse including whistleblowing policies and procedures.

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 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 that the provider was promoting safety through the layout and hygiene practices of the premises.

Learning lessons when things go wrong

● Incidents and accidents were recorded and reported on where necessary, to the appropriate authorities. The registered manager reviewed incident and accident data to identify any themes or trends, and actions were taken to make improvements and share learning points through team meetings and supervisions.

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 inadequate. At this inspection this key question has improved 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.

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

- Many of the improvements to the quality assurance systems we saw at the last inspection were still apparent. However, we found not all monthly audits had been completed thoroughly to identify the discrepancies in two of the three care plans and risk assessments we found.
- Systems that were audited included reviews of falls, accidents, incidents and care plans. We found that the registered manager took action when audits identified changes or improvements were needed.
- The registered manager had increased the staff supervisions and now included direct monitoring of staff providing personal care and administering medicines. That meant staff were given regular feedback on their performance and when required additional training could be provided if required.
- The staff were committed to achieving good outcomes for people, and understood each person's wants and needs. Staff were flexible in their approach to ensure good outcomes for people.
- We received positive feedback about the approachability and effectiveness of the registered manager who followed up when issues were brought to their attention. One staff member told us they had raised some concerns which had been promptly investigated by the registered manager and appropriate action taken.
- Staff gave mixed feedback about the stability and morale within the staff team. Not all staff felt they were treated fairly and equally. Some did not think everyone in the team worked supportively together, in part due to a turnover of staff. Others felt differently. One staff member told us, 'I feel valued and listened to. Some might not, but I do. I know there is some bickering amongst some staff, but that's not me."

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 fulfilled their legal obligations to notify the Care Quality Commission of serious incidents involving people.
- Staff were clear about their responsibilities and the leadership structure in place. People's relatives said they knew registered manager and said they had been contacted to make them aware of changes in their relations condition. One relative said, "We've had emails about changes, the latest email from the home included the practice for visiting our relative, we had a conversation about visiting and are conscious they want to remain COVID free."

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

characteristics

● 'Resident' meetings took place regularly but not everyone we spoke with said they were aware of them. We spoke with the registered manager who sent us the minutes from the monthly meetings in January and February this year. They also included the planned dates for the rest of the year. Topics discussed included the Christmas festivities, complaints and the procedure when a fire alarm sounded. People were also asked about any proposed changes to the menu and any work that was about to take place on the fabric of the building.

● People's relatives were contacted by the registered manager and staff and informed of changes in people's health. However, relatives we spoke with confirmed they had not been sent any questionnaires or asked their opinion about changes in the home. We spoke with the registered manager about this and they said that due to postal restrictions resulting from the pandemic they called relatives for a telephone survey.

● Team meetings were held to ensure staff stayed up to date. Minutes of meeting showed that various topics and updates were discussed with staff on a regular basis. This ensured staff were made aware of any changes in the service or requirements.

Continuous learning and improving care

● We found that audits and checks took place within the service. Improvements and changes were carried out when necessary.

● There were some improvements being made to the building at the time of our inspection which included changes to flooring in communal areas. Further changes were planned to take place later in the year.

Working in partnership with others

● The registered manager demonstrated how they and the staff group worked in partnership with local hospitals, commissioners, the local authority safeguarding team and other healthcare professionals to try to meet people's needs consistently. One staff member told us, "They always speak immediately with the GP, and the district nurses come very quickly."

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 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were enough numbers of staff deployed to meet people's needs.