Magicare Limited

Priscilla Wakefield House

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We carried out an unannounced inspection on the 19 February 2015 and announced inspection on the 23 February 2015.

Priscilla Wakefield House provides residential and nursing care to up to 112 people. At the time of our inspection there were 101 people living at the service. There are five units in the service. Copperfield and Haversham for people requiring nursing care; Nickleby for residential care, Dorrit for people with dementia and nursing care and Pickwick for younger adults who may have dementia, brain injury or physical disability and who required nursing care and rehabilitation.

There is a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

At our last inspection on 23 June 2014 we found several breaches relating to respecting and involving people who used the service, care and welfare, cleanliness and

Summary of findings

infection control, and staff support. We told the provider to take action to make improvements. We received an action plan from the provider stating that these actions would be completed by end of November 2014.

Since our last visit in June we found that the provider had made a number of improvements and met the actions detailed in their action plan. We saw that the provider had implemented a new cleaning system to ensure that cleanliness and infection control practices were adhered to. Staff had received regular supervision and relevant training in DoLS (Deprivation of Liberty Safeguards) and the Mental Capacity Act 2005 (MCA). The registered manager and staff had worked closely with the local authority quality team to improve the quality of care at the service and staff knowledge of DoLS and the MCA. This included the introduction of a DoLS/MCA champion. They had employed an additional activities coordinator in September 2014, bringing the total activities coordinators to four. New care plans and risk assessments had been implemented and we saw evidence of these on the day of our visit.

We saw some good interactions between staff and people living at the service. People and relatives told us that staff were caring and kind. People were given choice and their individual needs were being met by the service. Staff were caring and kind when interacting or assisting people with personal care.

People were treated with dignity and respect and their privacy maintained. We saw that staff knocked on people's doors and gave people time to respond before entering.

People consistently received their medicines safely and as prescribed.

Staff told us that there had been improvements since our last inspection. They said that they had received regular supervision and felt supported by their manager.

People had their nutritional needs met by the service and referrals to other healthcare professionals to assist staff to meet their needs.

Systems for monitoring the quality of the service were effective. The provider had employed an external auditor to review the standards of care. Their last report produced in January 2015 had highlighted areas for improvement. We found these matters had been addressed on the day of our visit.

The registered manager is aware and has identified further improvements to ensure people's care plans were updated following a change in their need. Forms used to assess people's mental capacity required further review to ensure the information was accurate and made clear whether people had given consent and who was involved.

We found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to consent. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from the risk of infection because the provider had systems in place to ensure the environment was clean.

People consistently received their medicines safely and as prescribed.

Staffing numbers were sufficient to meet people's individual needs. However, relatives and staff felt more staff were needed at weekends and at busier times.

Is the service effective?

Requires improvement

The service was not always effective.

Staff received regular supervision and training. They told us they felt supported by their manager.

People's nutritional needs were met by the service.

People were referred to other healthcare professionals to assist the service with meeting their individual needs.

Staff received training in the Mental Capacity Act 2008 and DoLS. However, some improvements were needed to ensure that people who could not consent had their capacity fully assessed.

Is the service caring?

Good

The service was caring.

Relatives told us that their relative was well cared for and treated with dignity and respect.

People's likes and dislikes were recorded in their care records.

People's relatives were involved in their care and attended reviews of their care.

Is the service responsive?

Good

The service was responsive.

Activities were arranged in line with people's interests and abilities. Relatives told us that they felt their relative had opportunities to take part in social activities.

People and relatives were able to make complaints. Relatives told us that they felt the service listened and acted on their concerns.

The service supported people to maintain contact with family and friends who were able to visit anytime.

Summary of findings

Is the service well-led?

Good

The service was well led.

People were protected from the risk of poor care and treatment because the provider had systems in place to monitor the quality of the service.

People and relatives told us that they knew the registered manager and that they were able to approach her with their concerns.

Priscilla Wakefield House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over two days on 19 and 23 February 2015. The first day was unannounced and the second day was announced after our first visit. We reviewed how medicines were managed and administered. We also reviewed additional care records.

The inspection team consisted of three inspectors, an inspection manager, a specialist professional advisor in nursing, pharmacist inspector and a bank inspector.

Prior to the inspection we reviewed information we held about the service, this included notifications received from the service and other information of concern, including safeguarding notifications.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We talked to 22 people using the service, 15 relatives and friends, and 23 staff including the registered manager, deputy manager, clinical leads, activities coordinators, unit managers, senior care workers, care workers and housekeeping staff. We reviewed care records and risk assessments for 21 people using the service. This included care plans in relation to specific care of pressure ulcers and special dietary requirements. We reviewed training records and staff personnel files for four staff and reviewed medicine administration (MAR) records for 64 people.

During feedback about the inspection we asked the provider to send us information on relatives and healthcare professionals, and a copy of the services complaints procedure. This was sent promptly following our visit. We contacted 19 relatives and managed to speak with 10. We also spoke to three healthcare professionals.

Good

Is the service safe?

Our findings

People told us that they felt safe living at the service. One person told us, "I feel safe and I like it here." Another commented, "I feel safe and happy." In one unit where people spent the day in their rooms, people said staff checked up on them regularly. One person told us, "They look after you well, there's always someone popping in and out."

Relatives told us that they felt their relative was safe living at the service. Comments included, "I have never had any worries since [relative] moved in," and "Yes, we've been very happy."

People were protected from the possible risk of abuse because staff demonstrated a good understanding of how to safeguard people living at the service. Staff had received appropriate training. Staff demonstrated appropriate awareness of safeguarding processes. They were able to tell us the signs and types of abuse they would look for that would indicate that people living at the service may be subject to abuse and the actions they would take. This included reporting in the first instance to the registered manager and if not satisfied with actions taken by the provider they would contact the relevant authorities, including the local authority safeguarding team, police and CQC.

On the day of our visit we saw that there were sufficient staff on duty to meet people's needs. During mealtimes we saw that staff were able to care for people seated in the communal dining room and in their rooms. The registered manager told us that staffing levels were assessed using a dependency tool. Dependency levels were assessed monthly and are based on people's individual care needs.

However, staff and relatives told us that the service was sometimes short-staffed, especially on weekends. Comments included, "Weekends tend to be a problem", "On the odd occasion they seem a bit short, such as when they take someone to the hospital", "Most of the time, not always, mainly lunchtime" and "Sometimes they could do with a bit more staff."

People were protected from the risk of acquiring an infection. The service had an infection control policy which provided guidance for staff. We saw that the service was clean and tidy and free from offensive odours. There were cleaning schedules detailing the areas to be cleaned and the frequency. There were hand washing facilities available throughout the communal areas, including hand sanitisers and paper towels. We saw that these had been checked and monitored by the housekeeping manager.

All the relatives and healthcare professionals told us that they felt the environment was clean. Comments included, "I have no issues with this, cleaners are always around." One person living at the service confirmed that there was "daily hoovering and polishing" of their room. They confirmed that staff always wore gloves when helping them with personal care. A visitor also commented that the service was, "Kept clean." We observed this on the day of our inspection. We saw that housekeeping staff cleaned in all the units throughout our inspection, including people's rooms and toilets.

Staff followed infection control principles, for example, we observed staff wearing protective clothing, for example putting on disposable gloves and an apron when attending to personal care. People had individual slings and sliding sheets. However, in one unit within two of the three communal bathrooms and toilets we checked, two bins for general waste did not have lids, which failed to store waste securely.

We observed that staff checked and recorded the temperature of hot foods in the hot-trolley before serving. However, improvements are required to ensure that practices were followed to ensure that action is taken where food temperature was too high to safely store items requiring refrigeration. We reported this to the registered manager and deputy manager who took immediate action to rectify the matters.

People's care files included various risk assessments, such as for bed-rail use, falls, manual handling and choking. In one unit we saw that staff used the appropriate moving and handling techniques and the recommended size sling with a full body hoist to transfer someone from their bed to their chair. In another unit we saw staff following the plan arising from the manual handling assessments for two people, for example, in using a standing hoist to help someone move from a wheelchair to a dining chair. Staff explained the manoeuvre to the person and talked to them throughout the transfer. Staff paid attention to the person's safety, for example, in holding the transfer bar secure when taking the sling off of it, so that the bar was prevented from swinging and potentially hitting the person's face.

Good

Is the service safe?

People had pressure care risk assessments which were regularly reviewed. We checked the repositioning charts for eight people who were identified as at high risk of developing pressure sores. In one unit we saw that the charts were up-to-date and showed that each person had been supported to reposition in line within their care plan. We heard staff making plans to reposition people, and saw that they had provided the support to people. In another unit we saw that these were managed and the risk assessment was updated on a monthly basis. However, in one person's plan we saw that the review of their pressure care risk assessment had identified increased risk nine days before our inspection, but their care plan had not been updated to reflect actions being taken to address this. We brought this to the attention of the registered manager and deputy manager who immediately addressed the issue.

There were systems in place to ensure that people consistently received their medicines safely, and as prescribed. Two people told us that they received their medicines correctly. "They always remember the tablets," one person said.

We saw appropriate arrangements were in place for obtaining medicines. Staff told us how medicines were obtained and we saw that supplies were available to enable people to have their medicines when they needed them.

As part of this inspection we looked at medicine administration records for people living at the service. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded.

Where medicines were prescribed to be given 'only when needed' or where they were to be used only under specific circumstances, individual when-required protocols (administration guidance to inform staff about when these medicines should and should not be given) were in place. They guided staff to ensure people were given their medicines when they needed them and in way that was both safe and consistent.

Medicines requiring cool storage where stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. We saw that controlled drugs were managed appropriately.

Requires improvement

Is the service effective?

Our findings

People spoke positively about staff. One person told us that staff helped them to book transport to visit their friend, adding “It’s a very nice place and staff are very helpful.” Another person told us, “Staff are friendly. They always seem to have a smile which is very important to me.” A third person said, “staff are nice.”

Staff told us that they had received regular supervision and said they felt supported by their manager. Staff told us that they felt that they had the right skills and knowledge to perform their role. Prior to starting work staff told us that they had completed an induction. Staff commented on the improvements since our last inspection in June 2014. Comments included, “I am happy and feel very confident to work with other health care assistants,” and “I have done DoLS (Deprivation of Liberty Safeguards), male catheterisation, wound management and will be booked for National Vocational Qualification (NVQ) level five management course.” Staff told us that they felt confident to practice. One care assistant told us they were completing NVQ level two in health and social care. They had their two-monthly supervision two days ago, and could explain how it focussed on their development.

We discussed training with the training manager who was appointed to this role in December 2014. He told us that all mandatory training was line-learning except moving and handling. All the information was yet to be transferred to the training matrix. We saw evidence of staff e-learning training records for all staff. This included common induction standards, customer care, DoLS, disability awareness, equality and diversity and principles of safeguarding. The training manger told us that the service was in the process of transferring from an old e-learning system to a new one.

Senior staff had received relevant training in DoLS and the Mental Capacity Act 2005 (MCA). The registered manager and staff had worked closely with the local authority quality team to improve the quality of care at the service and improve staff knowledge of DoLS and the MCA. This included the introduction of a DoLS/MCA champion at the service.

However, we noted where bedrails were used there were no capacity assessment about the person’s ability to consent to that proposal. A senior staff member told us that they would look into this, as they were unsure what was required. Although DoLS applications had been made at the request of the local authority, the information contained in the application was not always accurate. For example, in two people’s files this showed they used bedrails at night, however, this point was not made on the application.

We found consent forms were not always consistent. For example, in six people’s care records we saw that a consent grid was in use. Most answered yes to all questions, including 'can the person give consent' and 'if not is there a person for best interests?' These two answers were contradictory. Three files had two best interest signatures although none identified their name or their relationship to the person. There was a consequent MCA form that checked, for example, if the person had an impairment of the mind. However, it did not demonstrate that for each proposal, whether the four-step test of the person’s ability to understand, retain, use, and communicate the proposal had occurred. We also noted that one person’s bedrails risk assessment recorded that they agreed to use bedrails, which was in contrast to their mental capacity forms that stated they did not have capacity to consent to that proposal. The registered manager told us that although staff had been trained, further improvements are required and training is planned for staff in DoLS and the MCA. This was confirmed by the local authority quality team who told us that the service had been engaging with the team to improve their knowledge and skills in this area. These processes did not assure us that the service was acting in accordance with the Mental Capacity Act 2005 so as to uphold people’s rights.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People we spoke with were positive about the food although a few people had some reservations. Comments included, “The food’s very nice”; “Good food”; “Food's not bad, could be warmer”; “The food varies.” One person in their room confirmed that their meals were never forgotten about and they always had water to hand. However, in one unit one person explained that they could not read the menu nor make out what the picture was. We fed this back to the management team who told us that they would review the way the menus are presented.

We observed interactions between staff and people living at the service during breakfast and lunchtime. We saw that

Requires improvement

Is the service effective?

people who required assistance with feeding were supported appropriately. Staff maintained good interaction and maintained people's dignity. We saw that people who required assistance in their rooms were provided with this. For example, in one unit we saw staff took breakfast to one person in their room and explained to them what they were going to be doing before assisting them. We saw that the breakfast consisted of cereal with dried fruit, then egg, bacon, beans and toast. In another unit someone commented, "They come round and ask what you want," which we saw occurring during the morning. We noted that people had equipment to enable them to keep hydrated, for example, spouted cups or beakers with straws. Everyone had a drink to hand, and we saw that staff replenished and replaced these as needed.

People had their nutritional needs met. We reviewed nutritional plans and Malnutrition Universal Screening Tool (MUST). We saw that these were based on regular nutritional risk assessments. For example in one unit we saw that one person's plan was recently updated to show changes. This stated that they now needed support to eat.

Care records demonstrated involvement of other healthcare professionals. For example, there was evidence of dietitian referrals for two people following weight loss. In another example, we saw that two people were referred to the speech and language therapist (SALT). People with special dietary needs had specific instructions from the SALT displayed on the board in the nurses' station. Referrals were made to the tissue viability nurse (TVN) for two people for management of their pressure ulcers. The GP was involved in the management of illnesses, such as urine infection, chest infection and medication reviews.

Good

Is the service caring?

Our findings

People told us that they were looked after by staff. Comments included, “The staff are lovely.” Another person told us, “I like the staff here...they are very caring and kind...I like the meals... I feel happy”. A visitor told us, “The staff are nice.” We saw staff treated people respectfully. We saw that some staff, including an activities coordinator, had a very friendly approach. One person started smiling in response to this interaction.

Healthcare professionals spoke positively about the care provided by staff. They commented, “I find most staff quite caring,” and “yes, staff are caring.”

People received care relevant to their needs. One person told us that staff treated her kindly at all times, “they wash me and make me feel fresh.” We observed that people were well presented.

Relatives told us they felt their relative was well cared for. Comments included, “They [staff] are really good”, “Always keen and kind to [relative]”, “We’re happy with everything” and “On the whole we have been very impressed.” Most relatives told us that they were involved in their relatives’ care. They told us that they were able to come and go when they pleased. Therefore relationships with family and friends were encouraged by the service.

We observed that staff treated people with dignity and respect. Staff were interactive, polite and communicated with people in a respectful manner. We saw that staff knocked on doors before entering people’s rooms. People were appropriately dressed throughout our visit, and we saw that people received support with their appearance where needed. At one stage, one staff member noticed that a person was slumped in their chair. They asked the person to move themselves back up the seat, and provided safe support to do this. When it was clear that the person could move back no further, they asked the person if they could provide a cushion for additional support, which was agreed upon. The support provided to the person, and the fact that the staff member noticed, was an example of good care. In another example of good care, we saw two occasions where staff spoke to people in a familiar language, which the people responded to. A staff member told us that the person’s family had taught them phrases to assist their communication with the person.

People’s needs were assessed before their move to the service to ensure their needs could be met safely. We found that most care plans had recently been reviewed. They contained information on people’s likes and dislikes. Staff we spoke with understood people’s needs and were able to tell us people’s preferences. People confirmed that staff gave them choices. One person told us, “They make sure you know what the activities are.” Another person said, “People come in from the church frequently.” In one unit we saw an activities worker explain the afternoon activity to each person in the room, and inviting them to come along, which some people agreed to. We saw that people had a "My Life" document which was created by the activities coordinators. This document is kept in people's rooms and contains personalised information about people's life history, family and interests.

Records showed that people had information on file relating to their wishes for do not attempt resuscitation (DNAR). These were signed by the service’s GP, relatives and nursing staff. However, we noted that these were not originals. Following our inspection we received an email from the deputy manager informing us that ensure that future DNAR would be originals. We found two people on end of life care management had involvement from the palliative care team. The management team told us that staff had received training in end of life care. This was confirmed by the local authority quality manager, who had delivered the training. The registered manager was aware of the improvements required to ensure that people have advance care plans.

Good

Is the service responsive?

Our findings

Relatives told us that they were invited to relatives' meetings. One relative told us, "dates are displayed on the notice board at the service." We saw from records that relatives' meetings were held every three months and residents meetings held every six to eight weeks on each unit. Although most relatives told us that they attended meetings, some relatives said that they were unable to attend as these were held at times when they were at work. One person who used the service told us, "There's also residents' meetings now and again, you can bring up if there's anything wrong and they do fix it."

We looked at call bells for six people. We observed that call bells were accessible and people were able to reach them. We saw that these were promptly attended to. One person told us that staff responded "quick enough" when they used the call-bell. We saw staff being attentive to activations of the call-bell. However, we noticed that two people did not have their call bells in a position where they were able to use these. One person said, "They normally put out the bell." A staff member confirmed that the other person used the call-bell. Whilst we saw that people had other items such as drinks and television remotes to hand, we were concerned that by failing to leave call bells within reach, people's independence was not supported which could compromise their safety and welfare.

People's individual needs were met by the service. In one unit we saw that people's care files reflected a range of individual needs, for example, for various aspects of their health, how they communicated, and their morning and evening routines. The plans for the routines referred to people's preferences, for example, how they liked pillows on their bed and lighting arrangement at night. We saw that this was being met by the service.

Since our last inspection we noted that the service had employed an additional activities coordinator to ensure that people were stimulated. One person told us, "The activities are very good, there's old-time singing, cake baking, and we celebrated pancake night the other night." People had activity plans in place that focussed on ensuring that they were kept informed of the activities available. We saw that the activities coordinators had a programme of one to one activities as well as group activities. We spoke with the activities coordinators in two of the units and saw a weekly activities plan, which was displayed on the notice board on each unit. On one unit we did not see any activities taking place, however we were told that a few people had joined an afternoon activity on another unit.

People and relatives were able to make complaints. Nine of the ten relatives we spoke with told us that they knew who to complain to and said that the manager listened and acted on their concerns. One relative told us that they had made a complaint and this, "was dealt with straight away." We reviewed the complaints received by the service. We saw that the registered manager had responded to these in a timely manner.

Relationships were encouraged by the service. We saw the service supported people to maintain contact with family and friends who were able to visit anytime.

Good

Is the service well-led?

Our findings

People and relatives we spoke with knew who the manager was and where to find them if they had any concerns. One person told us, "…. is the manager, she always pops around to make sure I'm alright." A relative commented about management, "Management are brilliant and professional." Most relatives told us that the registered manager was very approachable.

Two people confirmed they would be happy to recommend the service to friends and family; none said they would not recommend. "It's a good service," one person added.

We discussed the needs of one person who had concerns about the way staff responded to their needs. The response of the registered manager helped assure us that they aimed to ensure that staff worked in a person-centred and empathic culture.

Systems were in place to ensure that people received quality care. We saw a quality assurance audit had been conducted by an external auditor in January 2015 and February 2015. This covered the CQC standards relating to the five domains, and asked how safe, effective, caring, responsive and well-led the service was. The audit included observations of staff providing care, and suggested areas for improvement. We also noted that the audits had identified areas seen on the day of our inspection, such as, process for evidencing whether people were able to agree to the use of bedrails. The report had also noted areas where we saw an improvement in the environment and general cleanliness of the building.

Staff told us they felt supported and motivated. We observed staff communicating well with each other. Comments included, "our manager is good," and "the manager is supportive, very nice but also very strict making sure the quality of care given is good."

We saw that the provider had carried out a staff survey in January 2015. In comparison to the previous year's staff survey, this had showed that staff were happier in the workplace. This was confirmed by staff throughout our inspection. We saw that the service had produced a spring edition newsletter, which included an update on the changes to the staffing structure and to the environment. However, the results from staff survey were not always followed through and the provider was yet to develop a questionnaire for healthcare professionals.

We saw that a resident's survey was conducted in December 2014. This showed that overall of the 13 questionnaires returned 28% felt that the service was excellent, 43% felt it was good, 21% felt the service was average, 2% said it was poor and 5% did not respond. Relatives confirmed that they had recently been sent a questionnaire to complete. This asked their views about the care provided to their relative and staff at the service.

We spoke with healthcare professionals who told us that the service had made improvements since our last inspection in June 2014. The quality team are working closely with the registered manager to improve the quality of care at the service, this includes conducting regular unannounced visits and observing staff delivering care and addressing any concerns with the registered manager.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people in relation to the care and treatment provided for them. Regulation 18**