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

Summary of findings

Overall summary

About the service
Wicksteed Court Care Home is a residential care home providing personal care to up to 25 people. The service provides support to older people, some of whom live with dementia. At the time of our inspection there were 15 people using the service.

People's experience of using this service and what we found
The provider had failed to achieve good standards within the home across multiple inspections. This service was registered with CQC on 26 October 2017 and in that time has failed to achieve a Good rating. This is the sixth consecutive inspection where the service has received a Requires Improvement rating or lower.

Contingency planning was not in place to manage a period of staff sickness within the home, leading to poor standards of care and cleanliness.

The environment had not been sufficiently cleaned. We found areas within the home which were dirty and needed cleaning, maintenance, and re-decoration.

People were not having their care needs met promptly. Staff were rushed as they had to complete extra duties with cleaning and cooking, as well as care tasks, due to staff sickness.

On the day of inspection, there was a lack of meaningful activity within the home as staff did not have the time to facilitate this. We received mixed feedback from staff about the support they received and morale within the service.
People were not always offered choice of what to eat and drink.

Staff were recruited safely in the service and received suitable induction and ongoing training. Medicines were administered safely by staff who were trained to do so.

A complaints policy and system was in place, and people knew how to use it. People's preferences, likes and dislikes were documented within care plans, and staff knew people well. End of life information and care planning was documented for those who wished to have it.

Audits and checks were in place throughout the service. Staff and people were able to feedback their views through questionnaires and meetings.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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
The last rating for this service was requires improvement (published 12 November 2021). The service remains rated requires improvement. This service has been rated requires improvement for the last six consecutive inspections.

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 received concerns in relation to staffing levels and care. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only.

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.

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

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We have found evidence that the provider needs to make improvements. Please see the safe, responsive and well led sections of this full report.

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 and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, staffing levels , person centred care and good governance at this inspection.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 always safe. Details are in our safe 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 well-led. Details are in our well-led findings below.	**Inadequate**

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 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
This 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 and/or personal care as a single package under one contractual agreement dependent on their registration with us. Wicksteed Court Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before 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
During the inspection we spoke with four people who used the service, five staff members including a senior care worker and cleaning staff.

After the inspection we held a meeting with the registered manager and deputy 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 inspection we rated this key question requires improvement. The rating for 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.

Preventing and controlling infection

- The service was not consistently clean, tidy, or well maintained. On the day of our inspection, we found that cleaning duties had not been fully undertaken by staff during a period of time when staffing was low due to sickness.
- Areas around the home had food and drink spillages that had not been cleaned promptly. The laundry area within the home was not clean. A sink area used in the laundry was stained and dirty, with an un-tiled wall area behind it that had paint peeling away from it. We found that used continence pads and personal protective equipment (PPE) were not always disposed of correctly and were found to be in open topped bins. Toilets we saw were not always cleaned promptly.
- Care staff told us they had been covering cleaning duties as the regular cleaning staff had not been at work. Staff said that extra staff were not brought in for these duties, and they therefore did not have the time to complete everything.
- This meant that people were at increased risk of harm due to poor infection control practices .

This failure to effectively complete cleaning duties was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was following government guidance for visiting procedures within the service.

Staffing and recruitment

- Staffing levels were not always sufficient to meet people's needs. Staff told us there was a large amount of staff sickness which had not been covered, and this had been the case for several weeks due to a sickness outbreak. Staff said they were having to pick up the extra duties of cleaning and cooking, as well as their regular care tasks, without any extra staff to back fill these duties. On the day of inspection, we found this to be accurate as staffing levels were low, meaning people were not being cared for in a timely manner.
- We saw one person was partially dressed and sat on their bed waiting for assistance from staff. When we asked staff, they told us the person was waiting for support with a shower, but the staff member had to go and peel potatoes in the kitchen first, as there was no chef at work.
- People were not receiving any meaningful activity or interactions from staff on the day of inspection. We observed staff were rushed and had to undertake cleaning and cooking duties alongside their care duties. The rota for the day of inspection was not accurate, as staff had called in sick and had not been replaced. This meant that people were not having their needs promptly met and were at increased risk of harm.

This failure to provide adequate staffing to the home placed people at increased risk of harm and was a

breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People and staff told us that staffing levels were usually ok, but had been short recently due to sickness. One person said, "We do normally have enough staff, but it has been a bit short." Staff we spoke with also confirmed they felt the issues they were having were caused by recent staff sickness, which was not resolved through any contingency planning.
● Staff were recruited safely. This included ID checks and Disclosure and Barring Service (DBS) checks before employment commenced. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe living within the service. One person said, "Yes I'm safe here, nothing to worry about."
●Staff were trained in safeguarding and understood how to report any issues. We saw records that showed appropriate referrals were made to the safeguarding authority when any incidents had occurred. Incidents had been investigated and actions taken.

Assessing risk, safety monitoring and management
●Risk assessments were in place to identify risks within people's lives. This included risks around skin care, eating and drinking, and mobility. Risk assessments were updated regularly, and staff had a good knowledge of risk.
●Any risks around the environment had been assessed. This included checks on the Lift, hoists, electrical systems and gas safety. Fire alarm system checks were regularly conducted.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Using medicines safely
● People received their medicines safely. Medicines were administered by staff that were trained to do so. Medicines were stored securely, and electronic medication administration records in use were accurate, and regularly checked for any mistakes. People we spoke with were happy that they received their medicine on time, and as they wanted.
● Where people were prescribed medicines to take 'as and when required' there was sufficient detail to guide staff on when to administer them safely and consistently.

Learning lessons when things go wrong

●Records showed that when incidents occurred they were documented and actioned. We saw that where lessons could be learned from an incident, this was documented and actions were taken, for example the re-training of a staff member.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained the same. This meant people's needs were not always met.

A t our previous inspection, we 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

●An improved programme of activity was set up for people to join in, and care plans contained personalised information, however, on the day of inspection, people were not receiving any meaningful activity. Staff told us they did not have time for any activities that day. One staff member said, "There are usually activities daily, but no activities today because we are short staffed due to sickness. Floor staff have to work in the kitchen and also clean, so we don't have time for anything else. It's been this way for a couple of weeks."

●During the lunch period, people were served a stew with both mash potatoes and roast potatoes. We did not see anyone offered a choice of which potato to have, or of a separate dish entirely. We asked staff who told us, "We are not trained cooks, if someone wants something else, we could make them a sandwich. We don't have enough staff."

These failures to provide meaningful activity and personalised care, were a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People we spoke with told us there was usually more activity going on, which they enjoyed taking part in, but staffing numbers had been short recently which had affected activities.

●People were encouraged to maintain relationships with friends and family. One person told us, "I have friends who come and see me and chat. They can come in whenever they want."

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

● People we spoke with were happy that staff knew them and understood their preferences, likes and dislikes. One person said, "The staff are very kind, they know me well. The staff come if I need something".

●Care plans we looked at contained information about people, their needs and preferences. Staff we spoke with understood the needs of the people they were supporting and knew them well. Staff were rushed on the day of inspection, but interactions they did have with people were positive and showed they knew the people they were supporting.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

●We saw that people's care plans contained an assessment to identify when people may need information in any different format, to be accessible to them.

Improving care quality in response to complaints or concerns
●We saw that a complaints policy and procedure was in place which involved the recording of any complaints, investigations, and follow up responses and actions to ensure lessons were learnt.
●People we spoke with understood how to make a complaint and said they would do so if required. An explanation of the complaint's procedure was displayed within the home for people to see.

End of life care and support
●People had care plans which contained end of life preferences and information. On the day of inspection we saw that a health professional was visiting a person to discuss their end of life choices so these could be documented properly for staff to follow.
●Staff had been trained in end of life care and support.

Inadequate

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 requires improvement. At this inspection the rating has changed 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.

Continuous learning and improving care

- The service was in breach of regulation due to poor staffing levels and poor quality of cleanliness in the environment, as detailed in the 'safe' key question of this report. During our inspection, the registered manager and the deputy manager were not present. The provider failed to provide sufficient contingency planning during a period of staff sickness, to ensure there were consistently enough staff on site. This resulted in people not receiving timely care and support in response to their needs and poor standards in care, which put people at increased risk of harm.
- On the day of inspection, there was a lack of sufficient leadership within the service, leading to poor staffing arrangements and standards.
- This service was registered with CQC on 26 October 2017 and in that time has failed to achieve a Good rating. This is the sixth consecutive inspection where the service has received a Requires Improvement rating or lower. Good care is the minimum that people receiving services should expect and deserve to receive. The provider has failed to achieve this standard.
- Governance procedures were not established and operated effectively to ensure the service consistently met regulatory requirements. A lack of effective contingency planning and oversight meant that people were not receiving good quality care at the time of the inspection.

This lack of contingency planning and failure to achieve and sustain a minimum overall rating of Good is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff and people did acknowledge that over time, some improvements had been made within the home, however, during this period of staff sickness, the quality within the home had deteriorated again.

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

- We received mixed feedback from staff about working in the home, morale, and the support they received. One staff member said, "Its stressful right now." Another said, "I feel sorry for the people living here." Another staff member said, "The registered manager is very good, a good person."
- Staff understood their roles and were confident in carrying out most tasks, but felt they were being asked to cover too many tasks. Care staff were being asked to cover cleaning and cooking tasks as well as their normal duties. One staff member said, "Care staff have to work in the kitchen and also clean, so we don't

have time for anything else."

● Staff knew the people they were supporting well and understood how to support people in line with their preferences and wishes.

● Audits and checks were carried out across the service. We saw that checks on areas such as medication, call bell logs, and PPE use has been carried out. These audits allowed for any issues to be identified and acted upon by management and staff.

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 management team understood information sharing requirements. We saw that information was correctly shared with other agencies, for example, when the service had identified concerns, and the management team sent us notifications about events which they were required to do so by law.

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

●People and their relatives were engaged with and asked to give their feedback on all aspects of care. We saw results of questionnaires that had been sent out to people and relatives, displayed within the home to show themes and trends within people's answers.

●A suggestion box was available for people to feedback any comments to management anonymously if they wanted to.

●The staff team had team meetings with managers to share information and updates. This included infection control, training, and updates about people living at the service.

Working in partnership with others

●The service worked in partnership with other health and social care professionals such as GP's and district nurses to support people to access healthcare when they needed it.

●The management team were receptive to feedback we gave.

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 9 HSCA RA Regulations 2014 Person-centred care Failure to provide meaningful activity to people. Poor person centred care around food on the day of inspection

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Poor levels of cleanliness within the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Poor levels of staffing within the service. Staff having to backfill duties for Cook and cleaners who were off sick.

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 17 HSCA RA Regulations 2014 Good governance Failure to ever be rated Good. Sixth inspection in a row rated Require Improvement or lower. Failure to provide contingency for period of staff sickness, resulting in poor care.

The enforcement action we took:

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