

Mi Care Wicksteed Court Ltd

# Wicksteed Court Care Home

## Inspection report

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## Ratings

Overall rating for this service

Inspected but not rated

Is the service safe?

**Inspected but not rated**

Is the service well-led?

**Inspected but not rated**

# 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 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 identified at the previous inspection and followed up on the warning notice that had been issued.

We found that the required improvements had been made.

Improvements had been made to the premises, so people were safe from identified risks. Risk assessments had been completed and were regularly reviewed to help reduce the risks known to people. People had Personal Emergency Evacuation Plans in place which reflected their needs to ensure their safety in the event of an evacuation.

Quality assurance systems had been improved. Auditing was 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 lessons were learnt to prevent further incidents. Staff supervisions were completed on a regular basis and a staff dependency tool was used to good effect to ensure there were enough staff.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection

At our last inspection the service was rated Inadequate (published 11 May 2020) and there were multiple breaches of the regulations.

### Why we inspected

We carried out an unannounced comprehensive inspection of this service in February 2020. Following this inspection, we served a Warning Notice in relation to breaches of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to the safety of the premises, insufficient risk assessments regarding peoples care and insufficient quality assurance systems.

We undertook this targeted inspection to check if the provider had made improvements and if they were now meeting the legal requirements. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns.

They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections cannot change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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](http://www.cqc.org.uk)

What happens next?

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.

Special Measures

The overall rating for this service remains 'Inadequate' and the service therefore remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements. If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### **Is the service safe?**

At our last inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

**Inspected but not rated**

### **Is the service well-led?**

At our last inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

**Inspected but not rated**

# Wicksteed Court Care Home

## Detailed findings

### Background to this inspection

#### The Inspection

We carried out this inspection to review the actions that had been taken following the last comprehensive inspection when we issued a warning notice.

As part of this inspection we also looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection control and prevention in care homes.

#### Inspection team

The inspection was carried out by one inspector and one assistant inspector.

#### 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 two people who lived at the home, one member 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 two people's care plans and reviewed three staff files.

# 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 inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess all of the key question at the next comprehensive inspection of the service.

At our last inspection the provider had failed to ensure the premises were safe and sufficient risk assessments were in place. This was a breach of regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements and was no longer in breach of this regulation.

Assessing and managing risks; Ensuring equipment and premises are safe

- Improvements had been made to ensure the premises were safe. For example, the laundry room had a lock fitted and this was in use, wardrobes had been attached to the wall and radiator covers were in use. This helped to ensure people were protected from known risks.
- Risk assessments were in place for people who had bed rails in place. These were reviewed regularly to ensure people were supported safely.
- People had Personal Emergency Evacuation Plans (PEEP) in place which reflected their current needs and were regularly reviewed. This meant accurate information was available to support people in the event of an emergency.

# 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. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess all of the key question at the next comprehensive inspection of the service.

At our last inspection the provider had failed to have sufficient quality assurance systems to adequately monitor the service. This was a breach of regulation 17, good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements and was no longer in breach of this regulation.

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

- Improvements had been made to the quality assurance systems. We found monthly audits had been completed in line with the providers procedures.
- Auditing systems included reviews of falls, accidents and incidents, care plans and bedrails. We found that the registered manager took action when audits identified required improvements. For example, the care plan audit identified that improvements were needed to include a list of each medication people took. The registered manager confirmed that each action was completed before the next monthly audit.
- The registered manager had improved the oversight of staffing. Staff supervisions were completed on a regular basis and a staff dependency tool was used effectively to plan staffing levels. This meant staff were given regular feedback on their performance and staffing levels were appropriate to meet people's care needs.