Wyncroft Care Limited

Wyncroft House

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

About the service
Wyncroft House is a residential care home providing personal and nursing care to up to 38 people. The service provides support to people living with dementia and people living with a range of complex health care needs. At the time of our inspection there were 19 people using the service.

People's experience of using this service and what we found
Care plans contained contradictory information about how to manage people's wounds. Topical creams were not administered as prescribed. There were no processes in place to ensure peoples pain relief medicines were monitored to ensure they were still in situ.

Appropriate checks were not carried out to ensure staff were recruited safely. Several staff files contained gaps in employment history, and risk assessments had not been completed for staff who had used their Disclosure and Barring Service certificate from their previous employer.

There were measures in place to prevent the spread of infection.
Incidents and accidents were recorded and analysed to identify trends however, there was no process in place for the provider to check if actions were consistently followed up.

There were systems and processes in place to protect people from the risk of abuse. People and relatives told us they felt safe. There were enough staff to keep people safe.

The systems and processes in place to monitor the service were not effective and did not consistently identify where improvements were needed. We were not assured the provider had embedded a culture of continuous learning.

People told us the manager was approachable and they felt comfortable raising their concerns. The provider engaged with people using the service. Staff worked with external health care professionals to ensure people received partnership care to meet their needs.

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 (09 March 2020).
At our last inspection we found breaches of the regulations in relation to safe care and treatment and good governance. The provider completed an action plan after the last inspection to tell us what they would do

and by when to improve.

At this inspection, we found the provider remained in breach of regulations. We also identified a new breach in relation to fit and proper persons employed.

Why we inspected
We received concerns in relation to the management of people's nursing care needs. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has not changed following this inspection and remains requires improvement

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.
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 read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wyncroft House on our website at www.cqc.org.uk

Enforcement
We have found breaches in relation to safe care and treatment, fit and proper persons employed and good governance at this inspection.

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

Follow up
We will request an action plan from 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 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Wyncroft House

Detailed findings

Background to this 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
The inspection was carried out by two inspectors and an Expert by Experience. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Wyncroft House 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.

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 not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return. 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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used all of this information to plan our inspection.

During the inspection
We spoke with 5 people using the service and 2 relatives about their experience of the care provided. We spoke with 7 members of staff, including the nominated individual, manager, the clinical lead, nurses, and care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with an Advanced Nurse Practitioner.

We reviewed a range of records, this included 8 people's care records and multiple medication records. We looked at 4 staff files in relation to recruitment and supervision. We reviewed a variety of records relating to the management of the service, including policies and procedures.

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 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 last inspection we found the provider systems were not always robust enough to demonstrate risks to people were effectively managed. 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 remained in breach of regulations.

Assessing risk, safety monitoring and management

- Risk to people were not consistently managed.
- Care plans outlining how to manage the risk to people who had wounds contained contradictory information and care was not always delivered in line with people's care plans. For example, a number of care plan contained contradictory information about how often wound dressings should be changed.
- Wounds were not always managed in line with best practice. Not all people who had wounds were identified when care planning, this meant staff did not consistently record information such as the measurement of the wound to assess whether the wound was improving or decreasing. However, staff knew how to support people with their wound management.

Using medicines safely

- Systems and processes in place to manage people's medicines were not effective in identifying where improvements were needed.
- People's oral medicines were administered safely and as prescribed. However, people's topical medicines were applied inconsistently.
- There were no Medication Administration Records (MAR) in place for topical medications, nor were there body maps in place to direct staff where to apply people's topical medications. However, staff were aware where to apply these. Guidance was in place for staff to record administrations within daily records however, this was inconsistent as (explain in what way). There was no process in place for the provider to oversee if people were receiving their topical medications as prescribed.
- There were no protocols in place to guide staff what to do if people refused their medications. However, MARs were updated accordingly.
- Staff documented when they had applied people's pain-relieving patches and recorded the site application. However, there were no checks in place to ensure the patches were still in situ as per best practise guidance.

Systems in place were not always robust enough to demonstrate risks to people were effectively managed

and that people received their medications as prescribed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● There were risk assessments in place for other health conditions and environmental risks. This helped staff support people.

Staffing and recruitment
● Staff had not been recruited safely and this put people at risk of receiving care and support from unsuitable staff.
● We reviewed 4 staff files, 3 of the files contained gaps in employment history. We discussed this with the manager who agreed to follow this up with staff.
● For 2 staff members the provider had used their Disclosure and Barring Service from their previous employment. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. This meant the provider could not be assured that staff were appropriate to be employed at the service and care with vulnerable people.

Systems in place were not robust enough to demonstrate staff had been recruited safely. This was a breach of regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were enough staff to meet people's needs.
● Staff received mandatory training to enable them to have the appropriate skills to complete their role.
● People and relatives told us staff responded promptly when called for assistance. One person said, "There is always staff about and there is always someone in the lounge. It's very good, they leave us the buzzer if we were in bed and if we need them, they come, we don't wait long." A relative told us, "There is always staff about, I don't see people waiting for assistance."

Systems and processes to safeguard people from the risk from abuse
● There were systems and processes in place to protect people from the risk of abuse.
● People and their relatives told us they felt safe. One person said, "The home just feels safe, I like living here, I'm happy here. They look after us, if I had any concerns, I would talk to someone and others I live with" A relative told us, "It felt like the right place from the start, I can go home and not worry about [Person]."
● Staff knew how to recognise the signs of abuse and report any concerns.

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

We found the staff were working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Learning lessons when things go wrong ●

The full process of reviewing accident and incidents was not always followed.

● There were systems in place to record accidents and incidents. These were analysed to identify themes or trends and actions identified to prevent the reoccurrence of similar incidents. However, no oversight was in place for the provider to check if actions had been followed up from accident and incidents that took place.

Preventing and controlling infection including the cleanliness of premises
● 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's infection prevention and control policy was up to date.

Visiting in care homes
● The visiting arrangements enabled people to maintain contact with their loved ones.

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 requires improvement. The rating for this key question has remained 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.

At our last inspection we found the provider's systems in place to review quality were not always effective. 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 remained in breach of regulations.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There were systems and processes in place to monitor the service, however, these were not robust and had not identified the concerns we found during the inspection.
- The service did not currently have a manager registered with the Care Quality Commission. There had been some changes in the management team recently and the provider informed us how the service is currently being managed and the plans for the acting manager to apply for registration.
- At the previous inspection it was identified the medication audit had not identified the failure to ensure there was a robust system in place for the administration of topical creams. At this inspection we found no improvements had been made to ensure people received their topical creams as prescribed. Nor had the audit identified the lack of checks in place to ensure people's pain-relieving patches were still in situ.
- There were no recruitment audits in place to ensure the provider could identify when staff files contained missing information or assurances put in place when staff used their DBS certificates from their previous employer.
- Although there had been improvements in some areas since the last inspection, we were not assured the provider had embedded a culture of continuous learning to improve care as some areas of concern from the previous inspection had not been effectively addressed. For example, risks not being consistently managed, the application of topical creams and concerns around recruitment processes not being robust.

The systems and processes to assess and monitor the quality and safety of the service were not effective. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider sought peoples', relatives and staff views through surveys and meetings. At the time of

inspection, the surveys were still in the process of been analysed due to being sent out the month before our inspection.

● People told us resident meetings took place. One person told us, "Once a month they ask everyone what they think and what they want to change, I think they do their best to change things." Another person said, "There are resident meetings all the time, they definitely listen to what you say." We reviewed the minutes for resident meetings and residents were happy with the care and support they received.

● People and their relatives told us the manager was approachable. One relative said, "I know the manager and see her about. If I had any problems, I'd ring. If I have any concerns all the carers and manager are approachable and tell you the truth, if any problems I would bring them up".

● Regular staff meetings took place and key staff met daily with the manager. Staff told us they found these meetings useful. One staff member said, "Yes we have a handover, and we are openly asked if there are any ideas or suggestions we can put in place to benefit certain residents, we are asked that on a daily basis".

Working in partnership with others

● The provider worked in partnership with external professionals to ensure people received a joined-up approach to their care. This included, the local authority, the GP, speech and language therapists and dieticians.

How the provider understands and acts on the duty of candor, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager understood their responsibilities in relation to duty of candor. The manager said, "It is being open and honest when things haven't gone right, identifying what went wrong and what could have been done better".

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 Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Systems in place were not robust enough to demonstrate staff had been recruited safely.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Systems in place were not always robust enough to demonstrate risks to people were effectively managed and that people received their medications as prescribed.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The systems and processes to assess and monitor the quality and safety of the service were not effective.

The enforcement action we took:

Warning notice