Bupa Care Homes (ANS) Limited

Wykebeck Court Care Home

Inspection report

York Road
Leeds
West Yorkshire
LS9 6NH

Tel: 01133682020
Website: www.bupa.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Wykebeck Court Care Home provides nursing and personal care for up to 84 people, some of whom may be living with dementia. At the time of our inspection, 45 people used the service.

People's experience of using this service: Staff did not always provide people with the care and support they needed to stay safe when moving around the home. This included access to appropriate equipment.

The provider did not employ enough staff or deploy staff effectively to keep people safe. Staff did not always respond to people who needed care and support and important duties such as pressure ulcer care were not always completed.

Restrictions had been applied to people without consideration of whether individuals might lack the capacity to make the decision. Where people did not have the capacity to make decisions, the documentation did not always support compliance with The Mental Capacity Act 2005 (MCA).

There was a lack of managerial oversight of the running of the service. This placed people at risk of harm and impacted on the quality of the service people received staff had not received any additional training aligned to the specific and changing needs of individuals.

We received mixed feedback from staff about the support they received from the registered manager and deputy manager.

Thorough assessments were carried out of people's needs and care plans were regularly reviewed. However, staff were not required to read people's care plans and this impacted on their ability to provide effective care in a way people preferred.

Further adaptions to the environment were needed to better support the people living with experiences of dementia. We have made a recommendation to the provider about the suitability and design of the premises.

Responses to complaints did not include any information about how to take action if the person was not satisfied with how the provider had managed their complaint. We have made a recommendation to he provider about their complaints procedures.

We received mixed feedback from relatives, staff and external visitors about the caring nature of staff. Staff appeared very busy and we observed very little meaningful interaction or activity between staff and people.

The home was newly built and well maintained. The environment was clean and tidy and staff followed infection control protocols to prevent the spread of infection.

Medicines were managed safely and stored securely in a locked treatment room and access was restricted to authorised staff.

People had access to food and drink throughout the day and an evening menu was available to people at night. We received positive feedback form people and relatives about the high standard of the food.

Rating at last inspection: The was the first inspection of the service and this is the first rating for the service.

Why we inspected: This was a scheduled inspection for this service.

Enforcement: We identified four breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 around safe care and treatment, consent, staffing and governance.

Follow up: We have asked the provider to address the breaches of regulation we found during our inspection. We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

For more details please see the full report either below or on the CQC website at www.cqc.org.uk

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 effective?

The service was not always effective

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring

Details are in our Caring 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

Wykebeck 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: On day one, the inspection team consisted of three inspectors and a specialist advisor in governance. Two inspectors visited on day two of the inspection.

Service and service type: Wykebeck Court Care Home is a 'care home', with the availability to care for up to 84 people. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection: The inspection was unannounced.

What we did: Before the inspection we reviewed information we held about the service. This included notifications from the provider and we also obtained feedback from the local authority contracts and safeguarding teams. A notification is information about important events which the service is required to send us by law.

We also used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 10 people who used the service and four people's relatives. We spoke with seven staff members, the deputy manager, clinical services manager, kitchen manager, laundry assistant and maintenance assistant. In addition, we spoke with the regional director and a visiting health care professional.

During the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at four people's care plans, three staff recruitment files and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People did not always have access to the equipment or support they needed to keep them safe. The registered manager assessed the risk of people falling. However, staff did not follow the guidance in people's care plans of the control measures to adhere to, to prevent people from falling.
- Staff told us it was not a requirement to read people's care plans. This meant they were not aware of the support some people needed to move safely around the home. A staff member told us, "I've never seen a risk assessment".
- There was a lack of evidence the provider had analysed incidents and ensured lessons were learnt to reduce the likelihood of a future recurrence. Accident and incident records showed immediate actions taken, however, the was little follow-up information about any wider consideration of factors that may have contributed to the incident.

Systems were not in place to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- The home was newly built and well maintained. A health and safety committee, made up of staff and members of the management team, was in place and met regularly to address any issues.
- Fire safety equipment was in date and available throughout the premises.
- Staff received fire safety training as part of their induction when they started working at the home.

Staffing and recruitment

- The provider did not employ enough staff or organise staff effectively whilst on duty to meet people's needs and keep people safe and staff told us they often went without breaks and found it difficult to care for people.
- Some areas of the home were not staffed and staff did not always respond to people who needed care and support and important duties such as pressure ulcer care were not always completed and we found call bells sounded continually.

The provider did not provide sufficient numbers of suitably competent and skilled staff to meet the needs of the people using the service. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Systems and processes to safeguard people from the risk of abuse

- Staff received training in the safeguarding of vulnerable adults and all understood their responsibilities to

keep people safe and report any concerns.
● People, relatives and staff told us they felt the service was safe. A relative told us, '[Name of person] is as safe as can be'.

Using medicines safely
● Medicines were managed safely and stored securely,
● We checked the quantities and stocks of medicines for 23 people and found all balances to be correct meaning medicines had been given as signed by staff. Appropriate arrangements were in place for obtaining medicines, ensuring people's treatment was continued.
● Detailed guidance specific to each person was in place to enable staff to safely administer medicines which were prescribed to be given only as and when people required them, known as 'when required' or 'PRN'.

Preventing and controlling infection
● The environment was clean and tidy and staff followed infection control protocols to prevent the spread of infection.
● We spoke with a health care professional who told us the home was always clean when they visited. A relative told us, "It's always nice and clean'.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Ensuring consent to care and treatment in line with law and guidance
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 Act 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- Restrictions had been applied to people without consideration of whether individuals might lack the capacity to make the decision, examples of this included bed rails and assistive technology such as bed sensors.
- Where people did not have the capacity to make decisions, documentation did not always demonstrate that MCA principles were followed.
- Staff received training in the principles of MCA and DoLS but told us they couldn't remember this training. One staff member told us they did not fully understand the documentation and had not received any additional training.

This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff support: induction, training, skills and experience
- Staff completed an induction and training programme prior to starting work at the home. Some staff told us the induction was useful and others told us it did not prepare them adequately for the role.
- Further training was needed for staff providing end of life care and managing meal times.
- Staff received regular supervision and appraisal. Some staff told us they felt well supported and others said they did not feel supported and found the managers unapproachable.

Adapting service, design, decoration to meet people's needs
- The home was pleasantly decorated and furnished but required further adaptions to the environment were needed to better support the people who lived on the second floor.
- People in this area of the home appeared withdrawn and unstimulated. One person told us, "I often walk

up and down here", referring to the long corridor outside their bedroom.
We recommend the provider refers to best practise guidance for providing accommodation for people living with experiences of dementia.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● A relative told us routine personal care for their relative had been missed on several occasions. They told us they had not been informed about a visit from a healthcare professional. This meant they had been unable to arrange a treatment for their relative at that time.

● We received positive feedback from a visiting health care professional about the communication they have with the management team at the home.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Assessments of people's needs and care planning were carried out but this did not always inform the care people received.

● Staff were informed of people's needs through shift handovers and by shadowing other members of staff. This was not always effective and people did not always receive the care they needed.

Supporting people to eat and drink enough to maintain a balanced diet

● People had access to food and drink throughout the day and at night and there were effective processes in place for managing dietary requirements and allergies. People and relatives told us they enjoyed the food provided. A relative told us, "The food is first class".

● Snacks were freely available for people to help themselves to and included fruit and biscuits.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; equality and diversity

- People were not consistently treated with kindness and respect. We received mixed feedback from relatives and a visiting healthcare professional about the caring attitude of staff. A relative told us, "Some staff are caring, some are not", another relative told us, "There is not one member of staff I am not happy with."
- We observed how some staff lacked concern for people who appeared distressed and or required support.

- Staff appeared very busy and we observed very little meaningful interaction or activity between staff and people. People sat for a long period of time in one of the lounges with little or no interaction from staff. People appeared withdrawn. One person asked to go to the toilet and was asked to wait for a few minutes for another member of staff to become available.

Supporting people to express their views and be involved in making decisions about their care

- Staff did not always care for people in the way they preferred.
- We observed staff and saw they did not follow the relevant guidance in one person's care plan. Staff did not offer any reassurance or emotional support to the person who appeared visibly distressed.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not always respected. A staff member told us, "I've walked in when people are not covered up during personal care; sometimes the doors are not closed."
- We observed a staff member openly ask someone about a recent medical examination in front of several other people.
- We saw how some people were not supported to be independent. For example, a staff member took cutlery from a person whilst they were eating; without asking if they needed any help.
- People were supported to maintain important relationships. Relatives and friends could visit people at any time and communal lounges were available for people to spend time in. People appeared happy and relaxed in the company of their relatives.
- One person we spoke we told us, "This is my house." Their relative told us the person was happy with the care they received.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
● People did not always receive the right support. Staff were not well informed about people's individual needs and preferences and people did not receive personalised care.
● Staff told us, "I've not read a care plan" and "I know some people better than others, I've not had time to look at care plans".
● During our inspection, one person moved from one area of the home to another. Limited information about this was provided to staff and they were not aware of the person's care and support needs.
● We saw how one person asked staff for a straw to drink with. The two staff members were unsure what the needs of the person were and the request was forgotten about and a different drink returned without a straw.
● The meal time experience for people living with dementia was not tailored to meet their needs. People struggled to use the standard cutlery and drink from wine glasses provided.
● Staff told us activities were not tailored to people's interests and staff had no time to engage in one to one activities with people. A staff member told us, "There is very little activity, when it happens it is good, but not often enough".
● The deputy manager was unaware of the Accessible Information Standard but could explain how people's communication needs were recorded their care plans. The Accessible Information Standard requires the provider to ask, record, flag and share information about people's communication needs and take steps to ensure people receive information which they can access and understand, and receive communication support if needed.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy in place and information about how to make a complaint was displayed for people and visitors to see.
● We looked at three recent complaints. Responses to these complaints did not provide any information about how to take action if the person was not satisfied with how the provider had managed and/or responded to their complaint.

We recommend that the provider reviews the complaints procedures in with regulation guidance for receiving and acting on complaints.

End of life care and support
● Staff had not received any additional training to provide end of life care for two people using the service at the time of our inspection.
● A relative told us their family member had become distressed and they waited 10 minutes before staff responded to them raising the alarm. They told us staff were not familiar with their family members care and

support needs.

● Professionals were involved as appropriate to ensure people were comfortable and pain free which included the availability of anticipatory medication.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

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

- The provider had failed to establish clear and robust governance systems at the service. This meant the management team were not clear about their roles and responsibilities.
- The service was not well managed. We consistently found there was a difference in understanding in how the management team believed care was being delivered and actual staff practise. As a result, people were placed at risk of harm and not having their needs met. This included, poor staffing levels, insufficient training aligned to people's care needs and legislative requirements, such as mental capacity assessment. There was a generalised lack of knowledge of people's needs.
- We did not see evidence of any in-depth analysis of incident data, such as identifying any themes or trends. This meant the provider failed to use the information which would contribute to continued learning and improvement in the standards of care for people and fulfilment of their own duty of candour requirements.

Systems were either not in place or fully embedded to demonstrate safety and quality was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- All appropriate reporting had been carried out to notify the CQC and local authorities when incidents occurred.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- We received mixed feedback from staff about the leadership of the management team and the culture of the service. Some staff told us they felt well support and felt comfortable raising concerns. Other staff appeared visibly upset when we spoke with them about this, and gave us examples of how they felt they had been discriminated against. A staff member told us, "There is a very big blame culture."
- Staff told us they did not have time to meaningfully engage with people and our observations supported this.
- Staff consistently told us they felt the service was not staffed to meet people's needs and that the registered manager had dismissed their concerns.
- People and relatives had recently completed a survey, expressing their views of the service. The deputy manager told us this information was used to make improvements.

● We received positive feedback about the deputy manager from a relative and a visiting health care professional who told us they were approachable and they felt able to raise any concerns.

Working in partnership with others

● The deputy manager told us the service was well connected in the local community and people often visited a local school to take part in celebrations; including the harvest festival and a Christmas concert.

● Photographs displayed in the home showed a recent fundraising event had taken place to raise money for a local charity.

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 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not always sought from people before care and treatment was provided. 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's safety had not always been mitigated. 12 (1) (2) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effectively established or operated to ensure safety and quality of the service. Regulation 17 (1) (2) (a) (b) (c) (f)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Regulation 18 HSCA RA Regulations 2014 Staffing
There were not sufficient numbers of skilled staff deployed to keep people safe.

18(1)(2)(a)