Review of compliance

Magicare Limited Priscilla Wakefield House	
Region:	London
Location address:	Rangemoor Road London N15 4LU
Type of service:	Care home service with nursing
Date of Publication:	August 2012
Overview of the service:	Priscilla Wakefield House is a care home registered to provide care and accommodation to 112 people. At the time of this inspection there were five units in the home; Nickleby for older people requiring residential care, Dorritt 1 and Dorritt 2 for older people who need nursing care and Havisham and Pickwick units for younger adults who may have dementia, brain injury or physical disability and who need nursing care. One floor in the home was vacant

	at the time of this inspection.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Priscilla Wakefield House was meeting all the essential standards of quality and safety inspected.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review to check whether Priscilla Wakefield House had taken action in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 05 - Meeting nutritional needs
Outcome 07 - Safeguarding people who use services from abuse
Outcome 09 - Management of medicines
Outcome 13 - Staffing
Outcome 16 - Assessing and monitoring the quality of service provision
Outcome 20 - Notification of other incidents

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 30 July 2012, carried out a visit on 8 August 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

We spent time in all five units in the home. There were 63 people living in the home at the time of our inspection. We spoke to people in four units.

People told us they liked the home, got on well with staff and felt they were well cared for. One person told us, "When I came here I was expecting the worst but the people are nice."Another person said, "It's nice here, the people are nice."

People said they liked the food. One person said, "The food is all right. They ask what I want." Another said, "They do the best they can." A third said, "I like the food, I enjoy it. They look after me." Another said the chef made them a cooked breakfast every day, no matter what time they wanted it.

Some people were unable to tell us what they thought about the home. We used a number of different methods to help us understand the experiences of people using the service, because some of the people using the service had complex needs which meant

they were not able to tell us their experiences. We spoke to the relatives of two people, who told us they could visit any time they wanted and were happy with the standard of care provided. One person thought they could benefit from more staff but had no concerns about the care provided. This person said, "I couldn't be happier. Some of the carers are good, but some really go over and above."

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We used this in three units. We found that people were contented and staff engaged with them in a senstive and supportive way to meet their needs.

At the last inspection of the home in February 2012, we made a number of compliance and improvement actions. Magicare Ltd told us they had made all the necessary improvements. We checked on these same things at this inspection to ensure the improvements had been made.

What we found about the standards we reviewed and how well Priscilla Wakefield House was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The provider was meeting this standard. People experienced care, treatment and support that met their needs and protected their rights.

Outcome 05: Food and drink should meet people's individual dietary needs

The provider was meeting this standard. People were protected from the risks of inadequate nutrition and dehydration.

Outcome 07: People should be protected from abuse and staff should respect their human rights

The provider was meeting this standard. People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

The provider was meeting this standard. The provider had the appropriate arrangements in place to ensure that people were protected against the risks associated with the unsafe management of medicines.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The provider was meeting this standard. There were enough qualified, skilled and experienced staff to meet people's needs.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The provider was meeting this standard. People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on.

Outcome 20: The service must tell us about important events that affect people's wellbeing, health and safety

The provider was meeting this standard. The requirement to notify the Care Quality Commission of specific events has been complied with.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We used this in Dorrit 1, Dorrit 2 and Havisham unit where people were less able to communicate. We found that people were treated with respect and staff were sensitive to their individual needs. Staff interacted positively, smiled and talked to people whilst helping them and checked regularly to see if people were comfortable. People were comfortable and settled. When somebody became unsettled we saw that staff would immediately try to help them and see what they wanted. We saw people had specialist equipment where needed.

We talked to five people about activities and how they spent their day. One person said, "When I came here, I was expecting the worst but people are nice."

There had been a recent trip to have a picnic in Clissold Park which people said they enjoyed. We asked two people in the home if they had enough to do during the day. They said they did. One person said staff organise karaoke and people enjoy it. We saw that one person who had been bored at the last inspection now had one to one staffing for part of the day and staff had taken them out on the day of our inspection. One person said they did not go out often but this was their choice and that they knew staff would go with them when they felt ready to go out.

In the units we saw staff supporting people with activities that were interesting and suitable for their ages and interests. In one unit, a member of staff was reading with

people and encouraging them to take part in a discussion. In another unit, people were supported in an art activity to make a picture for their rooms. Two people told us they were enjoying this.

We saw that one person had moved to another unit where their needs could be better met and this person was safe and happy during the inspection.

We returned to the home to do an unannounced visit at night. People told us they could get up and go to bed whenever they wanted. We saw that staff were supporting people by helping them get changed and making them drinks.

One person was walking around and going into other people's bedrooms and taking their spectacles. We looked at this person's file and there was no risk assessment for this. There was no guidance for staff on how to support this person and to stop them going into other people's rooms, taking their belongings and possibly frightening them. We reported this to the manager so that action could be taken. The provider may find it useful to note that a lack of risk assessment for this person meant that people in one unit were at risk of their privacy not being respected at night and their belongings not being safe.

Other evidence
At the last inspection we found that further work was needed to ensure care was provided appropriately to meet each individual's needs, risks to an individual 's safety and welfare had been identified and addressed, and that everyone had access to sufficient stimulating activities.

We looked at care records in detail for six people living at the home. We found that one person who did not have risk assessment for a high risk behaviour now had one. We talked to two staff about this person and found they knew his needs well and were aware of the risks to his safety.

Since the last inspection there had been two safeguarding alerts about people having pressure sores in the home. Both were substantiated. We looked at care records to see whether the home was fully meeting the needs of people who had a pressure sore or who were at high risk of developing a sore and also people who had challenging behaviour. We found that two people in the home had a pressure sore at the time of our inspection. The home kept records of the treatment plan for a pressure sore. They also consulted a tissue viability nurse for expert advice and help in both cases that we read about. We checked if the treatment plan was being followed properly. Records showed good care of two pressure sores. We saw records of care for another person who had a pressure sore. Records and photographs showed that this person had received appropriate care and the sore was improving.

One person had an abscess which had not been properly treated. This was an unmet health need. We found, from reading care records and talking to three staff about this person, that the home were trying to get expert medical help for this person and keeping good records. We saw that people at risk of developing sores had pressure relieving mattresses and one person had photographs of how they should sit and lie in bed to help staff ensure this person was in a comfortable position at all times. We saw two people with diabetes had care plans giving guidance on how to help manage their blood sugar.

The deputy manager told us that people living in the home received a good service from the local GP who visits weekly and when required.

We found one person was unwell at the time of the insection and was not eating and drinking properly. The deputy manager told us that a specialsit referral had been made for this person.

With one exception, there was evidence of people's physical health needs being met.

We saw that staff recorded that they turned people who could not turn themselves in bed. We checked four people's turning charts and saw that they were turned regularly to reduce their risk of developing sores. We talked to night staff and they all told us that they turn every person who cannot move by themselves regularly every four hours in the night.

We talked to the manager, staff and people living in the home about activities. The home didn't have a full time activity coordinator at the time of the inspection . There was a part time activity coordinator and care staff also engaged people in activities. In July there had been a table top sale, pet therapy, a park trip and smoothies in the courtyard.

We saw that people were living in a safe and stimulating environment. There were pictures on the walls and interesting things to look at.

Our judgement
The provider was meeting this standard. People experienced care, treatment and support that met their needs and protected their rights.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
People were satisifed with the food. Comments included; "The food is all right. They ask what I want," "They do the best they can. I don't like beans," and, "I like the food, I enjoy it. They look after me." Another said the chef made them a cooked breakfast every day, no matter what time they wanted it. Another comment was "the food is ok, you can ask for what you fancy."

For people who were not able to speak for themselves, we observed teatime in two units. We saw that a selection of food was prepared and people had a good choce of meals. We saw people received support to eat and drink from staff. We also looked at the food and fluid charts for two people who were fed directly into their stomachs by a peg feed. The charts showed they were receiving the recommended amount of food and fluid over the day and extra water had been given as the weather was hot.

Other evidence
One person's fluid chart was not accurate as it did not correspond with the amounts of fluid the dietician had recommended. The nurse said that the regime had changed but had not been recorded. She said it was not important that the exact amount of water and exact time were recorded. We reported this to the deputy manager who agreed to act on this immediately. Although there was no impact on the person receiving care, accurate record keeping for people fed directly into their stomach by Peg feed is important to reduce risks of dehydration or excess fluid. We saw that this person was receiving the recommended amount of fluid over the course of each day.

Records showed a choice of cooked breakfast or cereals and two hot meals for lunch

and an alternative if they don't like the two choices. We visited three units to look at what was served for supper on the day of the inspection. We saw people having choice of soup, quiche with baked beans, egg mayonnaise or ham sandwiches, spanish omelette, pasta, chicken nuggets and chips, sausage rolls and a cold meat salad. This was evidence that people could choose what they ate. There was a choice of desserts too.

We saw a night snack menu displayed in one unit. This said people could have a variety of hot and cold snacks and hot drinks. This was very positive and evidence of people being able to eat whenever they choose. In each unit there was fresh fruit and jugs of water and squash out for people to have between meals.

At the last inspection we found some people waited a long time for breakfast. The manager said that breakfast foods were available in each unit for those people who get up very early and the home had started serving breakfast earlier at 8am to meet people's needs.

People were provided with a choice of suitable and nutritious food and drink.

Our judgement
The provider was meeting this standard. People were protected from the risks of inadequate nutrition and dehydration.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We spoke to people but their feedback did not relate to this standard.

Other evidence
At the last inspection we found that unexplained injuries to people were not always reported and investigated.

We checked a sample of six people's care records to see if there were any unexplained injuries. We found two people in one unit had been found to have unexplained bruises. For one, records showed the bruise had been photographed and the person checked by their GP and an explanation for how the bruise occurred was recorded and who it was reported to. This was evidence of good care being provided.

We talked to two staff who showed good understanding of what to do if they noticed any bruise on a person. The deputy manager said that any unexplained marks are reported to her and discussed at weekly meetings with unit team leaders.

For the other person who had a bruise, the records did not show whether staff had tried to find out the cause or who the bruise was reported to. There was no impact on the person. The provider may find it useful to note that unexplained injuries which are not promptly reported and investigated could mean people are at risk of not getting medical attention when they need it.

The deputy manager told us she was improving the reporting form to ensure that staff

follow all the steps of investigating and reporting unexplained injuries and record all action taken. Overall, there had been improvement in the reporting of unexplained injuries.

We also found that one person had a grade 1 pressure ulcer which had healed but had not been reported to the deputy manager by the nurse in charge. This did not have an impact on the person's treatment. The provider may find it useful to note that a lack of vigilant reporting by nursing staff could mean managers are not aware of people's needs and could leave people at risk of their needs not being met. These reporting issues were in one unit. We did not find any concerns in the sample of records seen in three other units. We did not find any instances of unsafe or inappropriate care being provided.

Since the last inspection there had been three safeguarding alerts about medication which were substantiated. This meant that three people either did not get their prescribed medication or their medication was not given appropriately and safely. The manager told us that the nurse involved had been reported to the Nursing and Midwifery Council and was no longer employed. He said the home had also improved the monitoring by the management team of medication in the home.

In February 2012 we found staff had a good understanding of how to recognise and respond to signs of abuse. We did not look at staff training in safeguarding people from abuse at this inspection as we found at the last inspection that staff were properly trained by Magicare Ltd.

Our judgement
The provider was meeting this standard. People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

The provider is compliant with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We used a number of different methods to help us understand the experiences of people using this service. We talked to staff and looked at storage and record keeping of medication. We also observed medicines being given to three people at lunch time and saw that they were given professionally and with patience and encouragement and according to the preferences described in the individuals care plan.

We saw that one person was able to take their own medicines and that nurses were supporting this person and involving the prescriber with risk assessments.

Other evidence
During this inspection we looked at the medication administration records of the current medication cycle in three floors of the home. We saw that in the current cycle that all the appropriate arrangements were in place for recording medicines and we noticed no omissions in the records of receipts and stock balances and administration. This indicated that people's medicines were being given appropriately.

We carried out random audits of a total of 29 samples of stocks of medicines on the three floors to check the accuracy of the records and to see if medicines were being given as prescribed. All but one could be reconciled which indicates that medicines were prescribed and given to people appropriately. There was one discrepancy in a medicine to protect the stomach and this indicated that the medicine was signed for but not given.

We saw the weekly audits that managers were undertaking to identify recording and administration concerns and also the reminders on the medication administration records to record variable doses and complete other checks.

We saw that complex medicines such as oral anticoagulants and those with a variable dose were handled safely so that people's health was monitored. There were individual protocols in place for medicines prescribed as required, so that staff knew in what circumstances and what dose they should be given.

We observed that people experiencing severe pain had pain management plans so that staff could monitor the effectiveness of the medication and ensure that medication was administered in a timely manner.

For some people not able to swallow there were care plans in place to give medicines covertly and these were agreed by all the professionals involved in the person's care. For other people we saw protocols for feeding and giving medicines via a tube and we saw evidence that they were regularly reviewed and the appropriate formulations of medicines were prescribed so that the person's health was maintained.

We talked to one person who took their own medicines and were told that a risk assessment had been drawn up and was with the prescriber. We saw that the medicines were not in a locked drawer and were often loose from their packaging. But we were told that the risk assessment would address security and compliance to ensure that they were taken safely and as prescribed. We noticed that storage of medicines was secure on the three floors we inspected so that people were protected from harm. Stocks of controlled drugs were also secure and records accurate. Medicines requiring cold storage were stored in a fridge to maintain their potency and this was evidenced by the daily records of temperatures.

Overall the arrangements in place protected people against the risks associated with the unsafe management of medicines.

Our judgement
The provider was meeting this standard. The provider had the appropriate arrangements in place to ensure that people were protected against the risks associated with the unsafe management of medicines.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We spent two hours observing the home at night to see if there were enough night staff to meet people's needs.

We saw one person walking around and going into other people's rooms. This person needed close supervision by staff. We saw staff were busy trying to meet this person's needs as well as their other duties. Another person was calling out continuously. We asked this person if they were all right and what they wanted but they said they were fine. We read this person's care plan and saw that their calling out did not necessarily mean they needed staff attention. We talked to four people. They said they could go to bed whenever they wanted and that staff supported them if they needed help in the night.

Staff were very busy but there was no evidence of people's needs not being met.

One relative told us they thought Nickleby unit should have more staff.

Other evidence
We asked staff on Nickleby Unit if they thought they had enough staff. They said they could meet people's needs and that at night they could call on staff in another unit to help if they had any problem.

The manager told us that the home plans to appoint a part time physiotherapist to benefit people who have mobility needs.

At the last inspection we found that Magicare Ltd had not provided their own agreed staffing levels at night and therefore people had been at risk of their health and welfare needs not being met at night. We also found there was a lack of information to help determine whether staffing levels were sufficient to meet everyone's needs. The home had failed to have two nurses on duty on several occasions at night.

Magicare Ltd told us they would ensure they maintained their staffing levels at night at two nurses and seven care assistants at all times. During our inspection we met with the deputy manager to see how the home assessed people's night time staffing needs. An analysis had been done but this did not give information about people's night time needs. The deputy manager said she was devising a simpler assessment to be used to see how many staff were needed at night. She told us that there were always seven and sometimes eight care asistants at night to meet people's needs along with two nurses.

We returned to the home to check night staffing on 30 July at 10pm. We found that there were two nurses and eight care assistants on duty which was above the minimum agreed staffing level.

Our judgement
The provider was meeting this standard. There were enough qualified, skilled and experienced staff to meet people's needs.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We spoke to people but their feedback did not relate to this standard.

Other evidence
There was evidence that learning from incidents / investigations took place and appropriate changes were implemented.

Magicare Ltd employed an external person to undertake monthly quality monitoring visits at the home. We read the report of the last visit and saw that the report asked the manager to take action to make improvements. The manager told us that resident meetings were not well attended. He sent us evidence that people had been consulted for their views on the quality of care provided by surveys. He had analysed the surveys to see if any improvements were needed. The manager said that one of the directors from Magicare Ltd visits weekly to meet with the management team. The finance manager and deputy manager told us they wil be starting evening surgeries so that relatives who are at work during the day can come and talk to them with any queries about care or finances. All these were evidence of quality monitoring and ongoing improvements in the home.

Our judgement
The provider was meeting this standard. People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on.

Outcome 20:
Notification of other incidents

What the outcome says

This is what people who use services should expect.

People who use services:
* Can be confident that important events that affect their welfare, health and safety are reported to the Care Quality Commission so that, where needed, action can be taken.

What we found

Our judgement

The provider is compliant with Outcome 20: Notification of other incidents

Our findings

What people who use the service experienced and told us
We spoke to people but their feedback did not relate to this standard.

Other evidence
At the last inspection we found that Magicare Ltd were not notifying the Care Quality Commission of events in the home. These were legally required to be reported.

Since the last inspection, the management team have notiffied us of any deaths, incidents and safeguarding alerts as required. This has helped us to monitor the home more effectively.

Our judgement
The provider was meeting this standard. The requirement to notify the Care Quality Commission of specific events has been complied with.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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