Whitby Court Limited

Whitby Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Whitby Court Care Home is a care home providing personal and nursing care to older people, some of whom were living with dementia. The home can accommodate up to 50 people. At the time of this inspection, 38 people were using the service.

People's experience of using this service and what we found
Effective infection prevention and control measures had not always been in place or followed by staff and management. Risks in relation to transmission of infections had not been fully considered. This had placed people at risk of harm.

The registered manager had not always been open and honest when things had gone wrong. Systems and processes in place to monitor the quality and safety of the service provided had not always been effective in highlighting shortfalls.

There was enough staff on duty to ensure people's care and support needs were being met. Staff had been recruited safely and thorough recruitment processes were in place. Medicines were stored, recorded and administered as required. Staff had received safeguarding training and knew the process to follow if they had any concerns.

The registered manager and provider had used innovative ways to ensure people remained in contact with their relatives. People were happy with the care and support they received.

The provider and registered manager were responsive to the concerns and shortfalls found at the inspection. They took immediate action to address the concerns. They were committed to ensuring lessons were learnt when things had gone wrong and continuously improving the service.

For more details, please see the full report which is on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 18 April 2019).

Why we inspected
We received concerns in relation to poor infection prevention and control measures in place as well as staff not following government guidance in relation to Covid-19. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those

key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Whitby Court Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the Covid-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the Covid-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to infection, prevention and control practices and governance processes in place at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 safe findings below.

Whitby Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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 site visit was conducted by one inspector.

Service and service type
Whitby 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. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with CQC. 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
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection including recent whistle-blowing and relative concerns. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give 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 with the registered manager, administrator, senior carer and two care staff. We conducted a tour of the service to look at infection, prevention and control and Covid-19 management and observed staffs' practice. We also spoke with three people who used the service.

We reviewed a range of records relating to infection, prevention and control and Covid management. We also reviewed three people's care files, staff files relating to recruitment, training and supervision and a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found and clarify action taken to address the shortfalls found. We looked quality assurance records and contacted a further six staff.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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.

Preventing and controlling infection; Learning lessons when things go wrong

- We were not assured that the provider was meeting shielding and social distancing rules. Prior to the inspection, historical information had been shared which evidenced social distancing guidance had not always been followed or promoted.
- We were not assured that the provider was using PPE effectively and safely. Whilst staff were observed to be using PPE appropriately during the inspection site visit, information received prior to the site visit showed this practice had not always been followed.
- We were not assured that the provider was accessing testing for people using the service and staff. Staff had not always been tested at regular intervals in line with government guidance. At the time of this inspection, this had been addressed and a regular testing program was now in place.
- We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. There were specific days when domestic staff were not on duty, such as bank holidays. We could not be assured effective cleaning was in place during these times. The registered manager had taken action to address this at the time of the inspection.

Whilst we found that good infection prevention and control (IPC) measures were in place at the time of the inspection, evidence received prior to the inspection site visit showed that this good practice had not always been in place and followed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed all shortfalls found in relation to IPC and Covid-19 management had been actioned and a lessons learnt was to be completed.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider's infection prevention and control policy was up to date.

Assessing risk, safety monitoring and management

- Risks to people had not always been managed appropriately. People had been placed at risk of harm due to poor IPC practices and failure to assess and manage all risks relating to Covid-19.

Failure to assess the risks relating to the health and safety of service users is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and provider had taken action to address this.

● Risks relating to specific medical conditions and the environment had been assessed and recorded. These had been updated when changes occurred.
●Equipment had been serviced at regular intervals to ensure it remained safe to use.

Systems and processes to safeguard people from the risk of abuse
● People had not always been protected from the risk of abuse and avoidable harm due to poor historical IPC practices. The provider had taken action to address this.
● Appropriate referrals had been made when any concerns were raised.
● Staff had completed safeguarding training and knew the process to follow if they had any concerns. One staff member told us, "I would report anything I was concerned about."

Staffing and recruitment
● Staff were recruited safely, and all appropriate pre-employment checks were completed prior to employment commencing.
● There was enough staff on duty to support people. Staff and people we spoke with confirmed this. One person said, "If I need staff they are always around to help."

Using medicines safely
● Medicines were stored, recorded and administered appropriately.
● People told us received their medicines as prescribed. One person said, "I have had my medicines this morning. I never have any problems getting my medication."

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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.

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

- Systems and processes in place had not been operated effectively to ensure compliance with regulations. The registered manager had failed to identify and address poor practice in relation to Covid-19 management.
- Governance systems in place used to monitor the quality and safety of the service provided had not considered all areas, specifically in relation to Covid-19 and IPC practice. Where audits and analysis of incidents had been completed, these failed to identify and address all issues and shortfalls.

Failure to establish and operate effective systems to assess, monitor and improve the service provided was a breach of Regulation 17 (Good Governance) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider and registered manager were keen to learn and improve. They recognised the shortfalls found and took immediate action to address them. They demonstrated a commitment to continuously improving the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager had not been open and honest when things had gone wrong. They failed to report shortfalls in relation to Covid-19 management.
- We received mixed feedback from staff in relation to the culture of the service. Staff did not always feel the management team were approachable.
- People felt able to raise concern to the management team. One person said, "If I am not happy, I just tell them."
- The provider and registered manager were responsive to the issues and concerns found; they took immediate to address the shortfalls.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Innovative ways had been used to engage and involve people who used the service and relatives during

Covid-19 restrictions. A visiting pod had been created and technology had been used to enable people to communicate with relatives.

● The registered manager had strong links with other health and social care professionals. Visits from other professionals had continued to take place, in a safe way, during Covid-19 restriction to ensure people had access to the care and support they needed.

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 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate effective systems to assess, monitor and improve the service provided. 17((1)(2)(b)

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 The provider failed to ensure sufficient infection prevention and control measures were in place and that risks to people were thoroughly assessed. 12(2)(a)(b)(2)(h)

The enforcement action we took:

Warning notice