The Fremantle Trust

Icknield Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19, 20 and 21 June 2018. This was an unannounced inspection on the first day. We previously inspected the service on 23 January 2017. The service was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that staff had not received appropriate support, training and appraisal to enable them to carry out the duties they were employed to perform. We found during this inspection the provider had made improvements and were now meeting this regulation. However, we found the service was in breach of other regulations during this inspection. This was in relation to good governance and consent. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions in effective and well led to at least good.

Icknield Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Icknield Court accommodates 90 people in one adapted building. The service accommodates people across two floors, each of which have separate adapted facilities. There were six 'houses' or 'units', three of which specialised in providing care to people living with dementia. At the time of our inspection 87 people resided in the service. Four people received respite care.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, a new manager was in the process of applying to become the new registered manager.

People were kept safe at the service. Staff had received training in safeguarding people from abuse and staff told us they would not hesitate in reporting any concerns regarding people's welfare to the relevant authority.

We observed there were sufficient staff to support people at the time of our inspection. We saw that staff treated people with kindness and compassion. Comments included, "We all seem to be looked after properly here", "They do come quickly if you press your buzzer", "It is as close to being in your own home as it can be".

Staff told us they felt supported and had received supervisions from their line manager. Appraisals had been carried out in line with the providers policy and procedures.

Risk assessments had been carried out for people with an identified risk, for example, repositioning for

people with frail skin and fluid monitoring for people at risk of dehydration. However, the charts we saw were not always completed and some charts had not been completed at all.

We saw that recording of incidents such as bruising or skin tears were recorded in the handover record. However, it was not clear how these incidents were monitored. The service did not have an effective system relating to recording when bruising or skin tears occurred.

Medicines were mainly well managed. We observed the administration of medicines during our inspection and found people were safe from harm. Where medicine incidents occurred, these were investigated and address to prevent further occurrences. We saw that where people required regular pain relief to manage their pain a monitoring chart was not in place to establish the effects of the medicine. However, the manager told us this is something they will be addressing.

The service did not follow the requirements of the Mental Capacity Act 2005 (MCA). We found recordings of consent and best interest decisions were not always in place this meant the service did not comply with the MCA codes of practice. We did not find clear information in relation to people's applications, reviews and expiry dates for standard DoLS authorisations.
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the service policies and procedures did not support this practice.

People's nutritional needs were met and appropriate measures were in place where people were at risk of malnutrition. There was good partnership working with community specialists to monitor people's well-being.

Care plans were under review at the time of our inspection. We saw old versions of care plans and the new versions. We found conflicting information in the care plans we viewed. Some contained out-of-date information and changes to people's care was not always documented. We saw reviews which stated no changes. However, further information provided, confirmed this was not the case.

People had a range of activities to take part in to provide social stimulation. The service employed activity coordinators and local volunteers who provided a programme of activities.

Auditing of the quality of care took place. However, actions from the audits were still outstanding at the time of our visit.

We found two breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

Medicines were managed effectively.

Risk assessments were in place to monitor people's identified risks.

Systems and processes were in place to keep people safe from abuse. Staff understood the process to escalate their concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Consent was not always sought in line with the Mental Capacity Act 2005 (MCA).

Accurate recording of people's dietary and fluid intake was not followed to show what support had been provided.

People had access to healthcare professionals when required.

Is the service caring?

Good

The service was caring.

People's privacy was respected by staff who understood the importance of maintaining people's dignity

People were encouraged to personalise their rooms with furnishings from home

Is the service responsive?

Requires Improvement

The service was not always responsive.

Records did not always include up to-date information that was centred on the individual.

People had a range of activities they could attend to avoid social isolation.

The provider enabled people to make a complaint and were supported to do so if required.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider did not have effective systems and processes to continually monitor when incidents occurred.

Records did not record accurate information about people's support.

The service consulted with people and their families about how the service was run or any improvements that could be made.

Staff spoke positively about the new manager and looked forward to the changes ahead.

Icknield Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19, 20 and 21 June 2018 and was unannounced on the first day. The inspection was carried out by two inspectors and one 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. Their area of expertise was dementia care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We contacted healthcare professionals, for example local authority commissioners of the service, to seek their views about people's care. However, we didn't receive any feedback from the professionals we contacted. We spoke with the manager of the service, the deputy manager, the area manager, the chef, the activity coordinators, the administrator, seven members of staff and domestic staff. We spoke with 21 people who used the service and five visitors.

We observed medicines administration and records relating to the management of medicines. We viewed seven people's care plans and records relating to the care plans such as food and fluid charts and repositioning charts. We looked at recruitment files and training records. Other records included health and safety files, staff meeting minutes and quality assurance documentation. In addition, we viewed the accidents and incidents records, complaints and concerns records relating to the service provided.

Some people were unable to tell us about their experience of living at Icknield Court because of communication difficulties. We therefore used the Short Observational Framework for Inspecting (SOFI).

SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People told us, "We all seem to be looked after properly here", "They do come quickly if you press your buzzer" and "It is as close to being in your own home as it can be."

Staff received training in safeguarding adults. We saw contact details of the local authority displayed around the service. Staff told us they would not hesitate to report any concerns they had. Training on safeguarding was part of the training staff undertook when they first joined the service and was updated when required.

We observed call bells were answered promptly and that enough staff were on duty to meet people's needs. Shifts were covered by senior staff and duty managers in addition to care staff.

Risk assessments were implemented to reduce the risks associated with fragile skin, malnutrition and fluid intake. People who were identified at risk had charts in place for staff to monitor the associated risks. For example, staff monitored fluid intake, repositioning and dietary intake.

We looked at six fluid charts and repositioning charts and found these were not completed accurately. Some were blank and we saw one which had another person's name on it. This meant that identified risks were not appropriately monitored by staff. We discussed this with the manager and regional manager during feedback. They said they would reiterate to staff the importance of providing accurate records in relation to people's support needs. Staff told us they had repositioned people and offered food and fluids but had forgotten to record this.

We saw that recording of incidents such as bruising or skin tears were recorded in the handover record. However, it was not always clear how these incidents were monitored. The service did have body charts in place to monitor the injuries. But it was not clear if these were being monitored effectively by management. This meant there was a risk the service would not be able to monitor for trends which may require further investigations. However, we saw that when significant injuries occurred such as a fracture, the provider took appropriate actions in relation to this.

Medicines were mainly well managed. We observed the administration of medicines during our inspection and found people were safe from harm. Where medicine incidents occurred, these were investigated and addressed to prevent further occurrences. We saw that where people required regular pain relief to manage their pain, a monitoring chart was not in place to establish the effects of the medicine. However, the manager told us this is something they will be addressing.

Recruitment methods were robust to ensure only fit and proper staff were employed. We reviewed four staff files which contained all the required documentation, including criminal records checks via the Disclosure and Barring Service (DBS).

The management of risks associated with the premises were in place. We saw records of six monthly inspection and servicing for equipment including lifting and mobility equipment such as hoists, stand aids

and slings.

We saw that each person had a personal emergency evacuation plan in place in the event of a fire. During the second day of our inspection we observed a fire drill taking place. The manager said the staff responded correctly and the fire drill went well.

The premises were cleaned to high standards and appeared clean and free from obvious hazards during our inspection. We observed staff using personal protective equipment, for example, plastic aprons were worn as required.

Requires Improvement

Is the service effective?

Our findings

During our last inspection in January 2017 we found the provider was in breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured staff received appropriate support, training and appraisal as is necessary to carry out their duties they were employed to perform. During this inspection we found the provider was now meeting this regulation.

We received mixed comments from people we spoke with about the competence of staff. Comments included, "Getting old is not fun. You can't do the things you want to do and used to do but they do look after me", "It is like a roundabout here… people (staff) everywhere just rushing around… I say, 'slow down'" and "Yes, they do look after me here but I do have a little grumble sometimes if you have to wait over twenty minutes for them and they say they are busy."

Staff told us they felt supported by the new manager. We saw that supervisions and appraisals were taking place. This was confirmed by staff we spoke with and records we saw. A performance management system was introduced in the service to provide an overview of the performance of the staff team. Specific training in dementia care had been provided to ensure the people living at Icknield Court received appropriate care. This was in addition to the mandatory training the provider required all staff to complete. Records we viewed showed a high rate of completion in relation to staff training.

We saw that good nutritious food was provided for people living at the service. We spoke with the chef manager and they told us, "We have our board in the kitchen of people's food likes and dislikes. For underweight residents we will fortify the food and provide calorie shots." We saw records which confirmed this. The service used the Malnutrition Universal Screening Tool (MUST) to assess people's risk in relation to their food intake. MUST is a five-step screening tool to identify adults who are at risk of malnutrition. We saw people who were at risk of poor food intake had food charts in place. However, the charts were not always completed and some only contained minimal information. For example, three charts we looked at did not record that the person had any nutritional intake until the evening. However, staff told us people had eaten but they had forgotten to record this. We noted that the same issue was found when people were required to have their fluid intake monitored. Several charts we saw did not record what fluid people had consumed. We discussed our findings with the area manager and the manager of the service during feedback. They told us they were in the process of implementing new versions of people's food and fluid intake.

We found the provider was not always obtaining consent from people or their representatives. We saw several examples in people's care plans of where consent to sharing photographs, use of bed rails and consent to care and treatment was not authorised by people receiving care or their relevant other.
This meant a clear process for determining people's consent to decisions was not in place. In addition, care plans we viewed did not always have a capacity assessment for people who were deemed to have cognitive impairment. During our inspection we saw staff asking for consent from people before they carried out tasks with people.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 so that they can receive care and treatment when it is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

One person's care plan referred to '[name]' does not want to live in a care home. The person had advanced dementia and was on 24-hour supervision for their safety. However, we did not see records to evidence that consent had been obtained or a best interest decisions taken in regards to them living at Icknield Court.

Two people had bed rails in place without having clear records evidencing consent or best interest meetings. We asked to see best interest decision meeting minutes or outcomes and the provider was unable to provide this. This meant that where a person lacked capacity to make an informed decision, the service did not act in accordance with the requirements of the MCA. Decisions made on behalf of a person who lacks capacity was not recorded to provided evidence in line with the requirements of the MCA.

The manager told us applications for DoLs for some people had been made to the local authority but they had not yet been assessed. When we asked to see these applications the service was unable to locate them.

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

The design of the building was suitable for the needs of the people living at Icknield Court. People could navigate between rooms and floors using the passenger lift. There was an entrance area where people could sit and meet with family and friends.

The provider had regular contact with health and social care professionals to discuss people's health and well-being. We saw that community nurses visited the service when people required clinical support. We have not received feedback from healthcare professionals at the time of writing this report.

Good

Is the service caring?

Our findings

We found staff to be kind and caring towards the people they supported. We reported an occasion during our inspection of when staff did not act in accordance with the providers policies and procedures. The manager dealt with this incident immediately.

One person told us, "By and large they (staff) are very good." A member of staff overheard our conversation with a person; the person had expressly praised this member of staff. The person said, "She is very good". The member of staff was pleased and came over to us and said, "I bet she didn't know my name though." In fact, the person had used the member of staff's name correctly with us. The member of staff reacted by saying "I am amazed she has never got it right before". This demonstrated over time relationships between people and staff developed in a positive way.

We observed good interactions from staff towards people they were supporting. Care and support was given with attention to people's dignity and was provided in a respectful manner. For example, staff knocked on bedroom doors before entering and staff told us how they would maintain people's dignity by ensuring curtains were drawn and people were covered up when they were delivering personal care.

There were details of advocacy services available for people within the service. Advocates are people independent of the service who help people make decisions about their care and promote their rights. We were not aware of anyone accessing an advocate at the time of our inspection.

Staff we spoke with understood the importance of treating people as individuals irrespective of their gender, ethnicity or their physical or mental capabilities. The service had policies and procedures in place to guide staff.

Care plans we saw did not always contain people's preferences or life history. This meant care would not always be personalised for people. We discussed the care plans with senior staff and the manager. They told us care plans are in the process of being updated. One member of staff said, "I knew the care plans would be an issue. We have a lot of challenges." We saw in one person's care plan that said the person had a hearing impairment and refused to wear their hearing aid. However, there was no reference to how staff communicated with the person. We spoke with staff about this and they told us they used the person's communication board.
People were encouraged to personalise their rooms with items of furniture and personal belongings. Relatives were able to visit without restriction.

Confidential information and records were held securely and only accessible to staff working within the service.

Requires Improvement

Is the service responsive?

Our findings

People had their needs assessed prior to moving into Icknield Court. However, it was not clear from the records that people or their representatives had been consulted with their wishes and preferences recorded. Records we saw had not always been signed by the person where they had capacity to do so to confirm their acceptance and agreement to the content of the support needs. Where people did not have capacity, we did not see evidence of best interest decisions made which included a person's legally appointed representative or advocate when this was required. We discussed this with the manager during our feedback. They told us they would address this.

Care plans we viewed were not always personalised and did not detail specific personal preferences such as gender choice of staff and how people would like to spend their day. In addition, people's past life history was not always documented. This meant that staff would not be able to comment or discuss what people's lives and preferences were before they moved into Icknield Court. Two people told us, they were disappointed that some of the staff didn't really or necessarily get to know the real character of some of them.

Staff did not always have access to current up to date information that reflected people's needs. For example, we saw one care plan identified the person required regular repositioning to prevent skin damage. Another care plan referred to the person requiring their food to be monitored. However, when we spoke with staff and requested to see the food and repositioning charts, we were told these were no longer in place. We also saw examples of out-of-date information in some care plans which required archiving. For example, old skin tears and wounds dating back to 2016. In addition, when staff reviewed the care plans monthly, they often recorded 'no changes to care plan.' However, examples we saw did not confirm this. This meant conflicting information may cause inconsistencies in care.
We discussed this with the manager during our inspection. They said they are in the process of allocating specific duties to senior staff including updating and reviewing care plans. They told us at the moment, "We are all doing it (reviewing the care plans) if it is assigned to a specific member of staff it will be their responsibility."

We were told the care plans were being transferred into a new format and this was work in progress.

People could engage in activities and events that took place at the service. We saw a timetable of activities for the week ahead. There were various activities taking place during our three-day inspection. These ranged from chair based exercises and cake making. The sessions were well attended and people told us they enjoyed the social interactions. The service forged links with the community. We saw that the local school attended the service for special events which was well received by people who used the service.

The service used volunteers to assist with activities and we spoke with one volunteer. They brought in two dogs which people evidently liked to see. The volunteer commented, "I help out with other activities if required to. I come in for the Thursday coffee mornings and whenever they want me."

One person said, "They sometimes have bands here. It is quite good if you like it but I am hard to please." Another said, "We have quite a lot going on, but I tend not to go." We observed a 'seat exercise' class. Twelve people attended and the two activities staff were present. People were given long red ribbons. There was no music. There was a little banter and some people clearly had been before and knew some of the moves. Most people engaged and joined in. One person said, "Exercise is okay but I could do it on my own." We saw two people who had shown anxiety tendencies joined in.

It was announced by staff at the end of the thirty-minute session "The Activity tomorrow is in House Five and will be baking and cake making".

We were told that children were coming in from a local school later in the week. One person said, "Families can join us for lunch." Another commented, "It is good for me to mix. It makes a difference to have some company. I have been to all sorts of activities, although I think there are less of them in summer. I have learned lots of things and I have learned things that I have then used."
The service enabled people to have access to information they needed in a way they could understand. The service complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We saw notices displayed throughout the premises which enabled people to have information such as activities taking place community events and recent meetings. We asked staff how they made sure people who had visual impairments would know what is taking place in the service. They told us, "We would let them know." We saw some people had the use of an electronic tablet (computer) as a way of communicating with their family and friends.

We saw conflicting information in relation to people's do not attempt cardiopulmonary resuscitation (DNACPR) status. For example, in one care plan we viewed the information stated that the person does want to be resuscitated in the event of a cardiac arrest. However, we found that a DNACPR form was in the main office which had been signed by the person's GP stating not to resuscitate the person in the event of a cardiac arrest.

We discussed this with staff and the manager who told us the person's relative had agreed to have a DNACPR in place. However, there was no recorded information that this conversation took place. Staff told us they will ensure this information is transferred into the person's care plan. Other orders we saw were either signed by a hospital consultant when the person had been admitted to hospital and not reviewed when the person returned to the service or there was no conversation with the person or their relative when a decision was made by GPs. This meant that some people had not been involved and no capacity assessment took place or evidence that capacity had been considered.

We recommend end of life care is reviewed in line with best practice guidance.

People and their relatives told us they would raise a complaint should they have cause to. The provider had an accessible complaints policy and procedure in place. Where complaints had been received they were recorded with outcomes. The provider had followed duty of candour and had responded to individual complainants with outcomes. There was also a record of compliments from people and relatives.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager in post at the time of our inspection. However, the person managing the service was in the process of applying for registration with Care Quality Commission. One member of staff commented, "I find [name of manager] very enthusiastic. I think they will get the home to where it should be." Other comments we received were, "I am happy with the way [manager] is leading at the moment", "I have reported a few things and they have been acted on", "I feel supported", "It's early days yet", "All the managers we have had have had their different styles."

There were systems for monitoring the quality of care people received. We found action had not always been taken when issues were identified by the auditing process. For example, care plan audits carried out during May 2018 identified areas to be actioned such as, obtaining a photograph of people, identifying a key worker, ensuring a support plan was signed, and obtaining consent from people who used the service. We found these actions were still outstanding at the time of our inspection.

Systems and processes in place to ensure records were maintained relating to people's identified risks were ineffective. We saw records relating to monitoring food and fluid intake and repositioning people were not always completed to show what support had been provided.

Consent was not always obtained from people using the service or their representatives when required.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Records were not operated effectively to monitor the services provided.

The new manager was responsive to all the issues identified during our inspection. They told us they were working to implement changes such as ensuring staff record the care provided accurately and to update the care plans into a new format. They told us, staff will be reminded of the importance of accurate recording of people's identified risks.

The provider had sought the views and feedback from relatives and friends of people who lived at the home via a survey sent out in Spring 2016. 119 surveys were sent and 41 were returned. The overview was mainly positive with some areas for improvement. For example, responses indicated people wanted daily routines to be more stimulating and fun. Other suggested areas of improvement included the laundry services, hobbies and interests to be pursed and involvement of people in their care and support plans. We did not see an action plan to address the issues from the survey.

Providers are required to comply with the duty of candour statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying

on a regulated activity. The manager was familiar with this requirement and had an occasion where it was used.

Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. There are required timescales for making these notifications. We had been informed about incidents and notifications and from these we were able to see appropriate actions had been taken.

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 Care and treatment of people using the service was not provided with the consent of the relevant person

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not operated effectively to monitor the services provided.