HF Trust Limited

Wrekin Cottage - Telford (West Midlands)

Inspection report

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Date of inspection visit:
28 April 2021

Date of publication:
19 May 2021

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
Wrekin Cottage - Telford (West Midlands) is a residential care home that accommodates up to 16 people living with learning disabilities or autistic spectrum disorder. At the time of our inspection there were 16 people living at the home.

People's experience of using this service and what we found
People were not always safe as the infection prevention and control procedures were not effectively implemented.

The provider did not have effective systems in place to identify environmental issues which could put people at the risk of harm.

The provider did not have effective systems in place to identify and drive good or safe care provision. The management team failed to address all concerns, previously raised with them regarding the quality of service provided for people. The service did not have a registered manager in post at the time of the inspection.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Right support:
• Model of care and setting maximises people's choice, control and independence
Right care:
• Care is person-centred and promotes people's dignity, privacy and human rights
Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives.

Wrekin Cottage - Telford (West Midlands) was not able to demonstrate how they were meeting some of the underpinning principles of right support, right care, right culture. The care service had not been developed or designed in line with the values that underpin the Registering the Right Support and other best practice guidance. This was because Wrekin Cottage - Telford (West Midlands) provided accommodation for up to 16 people, some of whom were expected to use shared facilities including bathrooms and communal areas.

Wrekin Cottage was located within a 'campus' style location which contained other care homes with day centre facilities also on site. We were told the management team were looking to change the type of

accommodation offered to people living there to be in line with right support, right care, right culture guidance. However, no dates or plans for the proposed changes could be provided by the management team we spoke with.

People received their medicines as prescribed. Staff understood how to protect people from the risk of abuse and knew what to do if they suspected something was wrong. The provider followed safe recruitment practices.

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

Rating at last inspection
The last rating for this service was Requires Improvement (published 29 May 2019).

At the last inspection we found improvements were needed to keep people safe and to effectively monitor the quality of service provided. In addition, we found breaches in safety and quality monitoring. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the same breaches. Not enough improvement had been made/ sustained and the provider was still in breach of regulations.

The service remains rated requires improvement. This service has now been rated requires improvement for two consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about the management of the location. 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 remained the same. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

You can see what action we have asked the provider to take at the end of this full report.

Following our inspection site visit the provider took action to mitigate the immediate risks to people.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wrekin Cottage - Telford (West Midlands) 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 keeping people safe and the provider's monitoring of the provision of care at this inspection.

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

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 from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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 well-Led findings below.

Wrekin Cottage - Telford (West Midlands)

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
This inspection was completed by one inspector.

Service and service type
Wrekin Cottage - Telford (West Midlands) 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

At the time of this inspection the service did not have a registered manager in post. However, the day to day management of the location was being provided by the flexible support services manager.

Notice of inspection
This inspection was announced. We gave the service five minutes notice of the inspection. This was because we had to gather information on the home's current COVID-19 status and the provider's procedures for visiting professionals.

What we did before the 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.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service about their experience of the care provided and we spent time in the communal area observing the support people received. We spoke with five staff members including two support workers, a senior support worker, the flexible support services manager and a registered manager from a separate location supporting the flexible support services manager. We looked at several documents relating to the monitoring of the location and health and safety checks.

After the inspection
We continued to seek clarification from the provider to validate evidence found. This included seeking evidence regarding the actions they took to remove the immediate risks to people.

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 requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. The physical environment did not support effective infection prevention and control measures. These issues were a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Improvements had not been made and the provider is still in breach of Regulation 12 (Safe care and Treatment).

Assessing risk, safety monitoring and management
• People were not always safe from the risks of avoidable harm as the provider's risk management processes were ineffective. For example, the provider failed to ensure risk assessments in place were fit for purpose. We asked to see the risk assessment for the use of portable heaters. The assessment failed to identify the risk of burns as a result of contact with a hot surface. The flexible support services manager told us they hadn't read the assessment and had therefore not identified the omission.
• The provider failed to ensure all substances hazardous to health were stored correctly. We saw people had open access to industrial cleaning products which were not stored safely. This put people at risk of contact with hazardous substances.
• The provider failed to ensure all hot water pipes leading to radiators were adequately covered. This put people at the risk of harm of burns.
• The provider had failed to identify or rectify a broken stair banister rail which could lead to injury.
• The provider failed to ensure adequate fire safety and prevention measures were maintained. For example, they failed to identify recent repairs had left a significant hole in the ceiling above a fire door. This compromised the effectiveness of the fire prevention systems in place.

Preventing and controlling infection
• The provider failed to follow safe procedures for preventing the spread of infectious and communicable illnesses. For example, we saw doors where the varnish was worn exposing bare wood, rust on radiators, compromised sealant around washing facilities and stained lighting pull cords all of which hindered adequate cleaning.
• We saw parts of the home where there was evidence of ingrained dirt and staining and unknown substances on communal pieces of equipment. This included a trolley used to carry food and crockery which was also showing evidence of extensive rusting.
• Staff members, including the management team, did not fully understand what was expected regarding compliance with COVID-19 guidelines and visiting professionals. One staff member said they had an "ad-hoc" approach and some visitors wore personal protective equipment (PPE) and others didn't. We saw a sign stating what PPE must be worn. However, when the flexible services support manager and a registered

manager from another location arrived, they were not complying with these instructions.
• There was inconsistency regarding asking visitors about the symptoms of COVID-19 or temperature tests.
The lack of understanding regarding guidance and adherence to the provider's own instructions put people at the risk of harm of communicable illnesses.

Learning lessons when things go wrong
• The provider did not have effective systems in place to learn lessons when things went wrong. For example, we previously reported similar issues to those we found at this inspection. Despite being informed, the management team have failed to sustain improvements. However, the provider did have some systems in place. For example, if an error occurred with a person's medicines, they had systems in place to identify what went wrong and what could be done to minimise the risk of re-occurrence. This included retraining or disciplinary action if required.

Following this inspection site visit we received evidence from the provider confirming they had acted to remove the immediate risks to people. This included contact with the appropriate fire and rescue services to seek advice in rectifying the concerns we had raised with them.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. These issues constitute a breach of Regulation 12, Safe Care and Treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• People were supported by enough staff who were available to safely support them. People we spoke with told us they were supported when they wanted. We saw people were promptly supported when they needed assistance.
• The provider followed safe recruitment checks. This included checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions to prevent unsuitable people from working with others.

Using medicines safely
• People's medicines continued to be managed safely. People told us they received their medicines when they needed them.
• Some people took medicines only when they needed them, such as pain relief. There was appropriate information available to staff on the administration of this medicine including the time between doses and the maximum to be taken in a 24-hour period.

Systems and processes to safeguard people from the risk of abuse
• People were protected from the risk of abuse and ill treatment as staff members had received training on how to recognise and respond to concerns.
• We saw information was available to people, staff and visitors on how to report any concerns.
• The provider had made appropriate referrals to the local authority in order to keep people safe.

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 requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider did not have effective systems in place to identify improvement or drive good care. These issues were a breach of Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Improvements had not been made and the provider was still in breach of Regulation 17 (Good governance).

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• There was no registered manager in post at the time of this inspection. The previous registered manager de-registered in August 2020 and the flexible support services manager assumed the day to day management of Wrekin Cottage - Telford (West Midlands). However, the flexible support services manager was unclear about their role. They told us they hadn't checked or read risk assessments, were unclear about the provider's current COVID-19 policy and had not read the previous CQC reports. They went on to say they hadn't received a formal handover regarding the location from the provider before starting. Therefore, they were unaware of issues and hadn't subsequently taken action to rectify the concerns or drive improvements.

• The provider had ineffective systems to monitor the quality of the service they provided. For example, following a recent quality check several actions had been identified. We asked to see the report of actions completed. However, the flexible services support manager told us they had missed the deadline so hadn't completed it. The flexible services manager told us the provider failed to chase feedback on the actions required from the quality check. This indicated there was little effective oversite of quality or the actions highlighted to improve people's experience. Despite this lack of oversight, we were able to see some actions had been completed.

• The provider's internal quality checks failed to identify or correct the issues we found at this inspection. This included, but was not limited to, the compromised fire management system, checks to ensure touch points were able to be effectively cleaned, checks to ensure hazardous substances were appropriately stored and checks to confirm all staff were following the providers guidance on COVID-19.

Continuous learning and improving care

• The management team at Wrekin Cottage - Telford (West Midlands) failed to evidence they had kept themselves up to date with requirements in health and safety, infection prevention and control or fire safety.

We found no evidence that people had been harmed however, managerial oversite and environmental assessments were either not in place or robust enough to demonstrate their quality monitoring was effective. These issues constitute a breach of Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider did have other checks in place such as medication audits and care and support plan checks.
• The provider had appropriately submitted notifications to the Care Quality Commission. The provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale.
• We saw the last rated inspection was displayed in accordance with the law at Wrekin Cottage - Telford (West Midlands) and on their website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People we spoke with said the management team was approachable and they felt supported by them.

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 provider was aware of their responsibilities under the duty of candour. The duty of candour is a regulation which all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People told us they felt involved in decisions about where they lived including what to do and what to eat.
• One person told us about the garden and how they had changed things around which they enjoyed and found better.
• Staff members told us they found the management team approachable although they were looking forward to having a designated registered manager in post.

Working in partnership with others
• The management team had established and maintained good links with the local communities within which people lived. For example, GP practices and district nurses and social work teams.

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 systems and processes were in place to keep people safe from the risks of harm.

The enforcement action we took:

We issued the provider with a warning notice instructing them to make improvements and to be compliant with the law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure they had appropriate systems in place to check and maintain good care.

The enforcement action we took:

We issued the provider with a warning notice instructing them to make improvements and to be compliant with the law.