Wrottesley House Limited

# Wrottesley House

## Inspection report

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Date of inspection visit:
01 March 2019

Date of publication:
17 April 2019

## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|

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

# Summary of findings

## Overall summary

About the service: Wrottesley House is a residential care home that provides accommodation and personal care for up to 18 older people. At the time of the inspection the service was providing care to 16 older people, most of whom were living with dementia.

People's experience of using this service:

People were not supported by effective quality assurance and governance systems. The registered manager had not identified areas of risk and improvement required within the service. People's feedback was sought although positive action was not always taken where improvements were suggested or concerns were raised.

People were not consistently supported in a dignified way. While some interactions were kind, caring and dignified this was not always the case and some improvements were needed. People were offered choices but at times these were limited.

People had access to a limited range of leisure opportunities and activities. People were involved in planning their care where they had capacity to do so. Some improvements were required where people lacked capacity to make decisions. The provider was not always following the requirements of the Mental Capacity Act 2005.

We also some people did not receive care that met their needs and issues and concerns had not been identified and addressed sufficiently. Other people's needs were being met and risks were managed appropriately, however, this was not always consistent. We found risks were not always reviewed following accidents and incidents.

More information on our findings at this inspection are available in the full version of this report.
Rating at last inspection: At the last inspection completed 07 June 2016 we found the service to be good in all areas. The provider was meeting the requirements of the law.

Why we inspected: This inspection was a scheduled inspection based on the previous rating.

Enforcement: The provider was not meeting the requirements of the law around dignity and respect, the need for consent, safe care and treatment and good governance. Please see the action we have told the provider to take' section towards the end of the report.

Follow up: We have met with the provider and they have been asked to send an action plan detailing how they will make the required improvements. We will check these improvements have been made at our next inspection.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

**Is the service effective?**

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

**Is the service caring?**

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

**Is the service responsive?**

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

**Is the service well-led?**

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

# Wrottesley House

**Detailed findings**

## Background to this inspection

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

Inspection team:
The inspection team consisted of one inspector.

Service and service type:

Wrottesley House is a 'care home'. People in care homes receive accommodation and 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 care home accommodates up to 18 people in one adapted building.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was completed on 01 March 2019 and was unannounced.

What we did:
As part of the inspection we reviewed the information we held about the service. We looked to see if statutory notifications had been sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spoke with seven people who used the service and two relatives. We spoke with the registered manager, the cook and four members of care staff. To help us understand the experiences of

people we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people living at the service. We also carried out observations across the service regarding the quality of care people received. We reviewed records relating to people's medicines, five people's care records and records relating to the management of the service; including recruitment records, complaints and quality assurance records.

Requires Improvement

# Is the service safe?

## Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations have not been met.

Systems and processes to safeguard people from the risk of abuse

- People and staff members had raised issues about some staff practice during recent meetings and feedback surveys. These concerns had not been identified as potential safeguarding issues, they had not been reported to the local safeguarding authority and sufficient investigation had not been completed. As a result, plans were not put in place to protect people from further harm and they were exposed to ongoing risk.
- Some care staff we spoke with knew how to identify safeguarding concerns and where to report these concerns. However, others were not able to describe how they would identify and report signs of abuse.
- The provider's failure to develop robust safeguarding systems, to investigate reported concerns and to develop plans to protect people from further harm was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

Assessing risk, safety monitoring and management

- The registered manager had not ensured key risks to people within the service were recognised and appropriate action taken to minimise against the risk of harm wherever possible. For example; six people within the service had chest infections and two more people were showing signs of being unwell. The registered manager had not identified that nearly half of the people living in the service were unwell and had not taken action to protect people from any further harm.
- While we saw nutritional risks were managed well in most cases, this was not always consistent. We identified one person in the service was losing weight and insufficient action had been taken to protect them from the risk of harm. Care staff were unaware of the weight loss and we saw insufficient support being given at mealtimes. Care records did not reflect the weight loss or the person's needs and insufficient monitoring was in place. We found further concerns including nutritional supplements that had not been administered as prescribed.
- Where people had experienced accidents such as falls, risk assessments were not reviewed and updated to ensure the risk of further harm was avoided.
- The registered manager's failure to manage risks consistently formed part of a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Using medicines safely

- The registered manager had not ensured medicines management systems were robust and that people's medicines were always administered as prescribed. We found examples such as one person's nutritional supplement and creams that had not been administered as required.
- We found the stock levels of medicines did not always match the amount of medicines available as

outlined on people's medicines administration records (MAR). In one instance, there was less than 24 hours supply of nutritional supplements available for a person and no attempt had been made to order additional supplements.
•□The registered manager's failure to ensure medicines management systems were effective formed part of a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Preventing and controlling infection
•□People were not protected by safe infection control practices within the service. We saw care staff did not always have sufficient knowledge around good practice; for example, we saw a member of staff coughing into their hand then continuing to support someone to eat.
•□We found issues such as specific areas within the service smelling of urine and a lack of action where some people lacked capacity to maintain their own personal hygiene.
•□The registered manager had not completed any infection control audits since the last calendar year and had not identified the issues we found.
•□The provider's failure to ensure robust infection control practices were in place formed part of a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Learning lessons when things go wrong
•□The registered manager had not used incidents and accidents to learn lessons in order to ensure improvements were made in the future. For example; we found following accidents, risk assessments were not always reassessed in order to minimise the risk of repeat events in the future.

Staffing and recruitment
•□While some people told us there were enough staff, others did not. One person told us, "There's not enough staff". Staff also had varying views and while some told us there were sufficient staff, others said there were not. One staff member told us, "We don't have time to be with them one to one, it's just care".
•□The registered manager did not have an established system to calculate the staffing levels required in the service. They told us the staffing levels had been in place for several years and had not been reviewed as people's dependency levels had increased.
•□We saw there were sufficient numbers of care staff to keep people safe, however, there was limited time for staff to provide one to one support.
•□The registered manager had safe systems in place to recruit staff. This included the completion of identity checks, reference checks and a Disclosure and Barring Service check (DBS). DBS checks are completed to enable employers to review a potential staff members criminality to ensure they are suitable to work with vulnerable people.
•□We found the manager had not always applied recruitment systems consistently. For example; we found an example where a staff members employment history had not been fully checked with explanations sought around any gaps and inconsistencies with dates of employment provided.

Requires Improvement

# Is the service effective?

## Our findings

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

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

Ensuring consent to care and treatment in line with law and guidance

- The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
- People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
- We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
- Care staff we spoke with did not have a good understanding of the MCA. While some staff knew it related to mental capacity and decision making, they did not know how or what action they were required to take under the law to protect people.
- We found care staff were making decisions on behalf of people without the principles of the MCA having been followed; including completing a test of their capacity and recording how decisions have been made in people's best interests. Some of these decisions included the use of medicines, dietary changes and the use of movement sensor mats.
- In some cases discussions around decisions being made on behalf of people were taking place with appropriate individuals such as medical professionals and family members. However, this practice was not consistent and actions were not being recorded.
- The provider's ineffective application of the MCA was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent

Staff support: induction, training, skills and experience

- Care staff did not always have sufficient knowledge around areas such as the Mental Capacity Act 2005 (MCA). We saw this reflected in the care provided to people.
- People we spoke with gave us mixed views around the ability of the care staff supporting them. One person told us, "Some staff are ok, others not".
- Care staff told us they felt training was good and they received regular access to training opportunities. We saw from training records that training was provided regularly. We found however the registered manager was not consistently checking the competency of staff members in practice in their roles.
- We saw care staff were well intentioned and had a desire to provide good care to people, however, were not always skilled to recognise when care provided did not meet the required expectations. For example; we

saw examples of care staff supporting people to eat in an undignified way.

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

- Some people told us the food available to them was 'okay', others told us it was not. One person told us, "It's too monotonous". Another person said, "It's dull, it's dismal". People told us they were asked for their views around food but could not always think of examples of meals they might like when they were put on the spot. They told us when they made suggestions nothing changed. Some care staff supported this view and told us people's views were not taken into account sufficiently.
- We saw a menu was planned which gave people a choice of two options. The cook told us where people had requested specific items these were made available to them. However, consideration had not been made as to how people with reduced capacity could be fully involved in designing menus and choosing the food they ate.
- We saw where people required additional support to eat meals, this support was not always effective. For example; care staff were not consistently sitting down with people on a one to one basis to support them to eat where needed.

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

- We found some areas of good practice; such as effectively working with the local authority when people moved into the service. A relative of someone who had recently moved in told us the staff team had been proactive and efficient. We saw a care plan had been developed and the person's health needs had been considered.
- We found people were given access to support by a range of healthcare professionals; including doctors, nurses, chiropodists and opticians.
- We also found areas of practice that required improvement. For example; while professionals were involved in supporting people's care this was not always done in a proactive and timely way. We found one example of someone who had seen a dietician although further concerns had arisen and no action was taken to obtain further advice.

Adapting service, design, decoration to meet people's needs

- We found some aspects of good practice in terms of the use of the building. For example; there were three lounge areas that people could choose to spend their time in. One of which was a conservatory where people told us they enjoyed watching the birds and sitting in the daylight.
- Other areas within the service required improvement. For example, the service was not always kept well maintained and we saw threadbare carpets in some areas. We also found the service was not meeting best practice guidelines around dementia friendly environments.

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

- We found care plans were in place that demonstrated people's needs had been assessed holistically. Consideration had been made to people's nutritional needs, physical health needs and personal interests while planning the care and treatment they should receive.

Requires Improvement

# Is the service caring?

## Our findings

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

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

Respecting and promoting people's privacy, dignity and independence
•□We saw examples of good practice, such as staff offering to support people with personal care in a discreet, respectful and dignified way. However, we found this was not always consistent and we saw examples of care staff not upholding people's dignity.
•□We saw care staff failed to support people with one to one support at mealtimes in a dignified way. For example; we saw care staff standing over people while supporting them to eat and not engaging with the person or explaining what they were doing. We saw one example where care staff would walk up to the person, stand over them and put a fork full of food towards their mouth then walk away again. While some care staff supported people while seated at eye level and demonstrated patience and respect, this approach was not consistent across the staff team.
•□We saw further examples of poor practice in terms of people's dignity being promoted. For example, we saw all people within the service were given plastic beakers to drink from without there being a specific need for this in order to manage people's safety. We also found some people were left seated after mealtimes with clothes protectors on for extended periods of time.
•□The provider's failure to ensure people were consistently treated with dignity and respect was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Dignity and respect

Ensuring people are well treated and supported; respecting equality and diversity
•□Some people and relatives told us they felt all staff were kind and caring towards them, although others told us the approach of the staff team was not always consistently caring.
•□Care staff we spoke with were well intentioned and committed to their roles, however, we saw in practice care staff did not recognise when interactions were not kind and caring towards people. For example; we saw poor one to one support and periods of time where care staff were present in the same room as people but did not interact with them.

Supporting people to express their views and be involved in making decisions about their care
•□People were supported to express their views although they did not feel heard. Some people told us when they expressed views about things such as care staff or food no action was taken.
•□People were able to make basic choices about things such as where they wanted to spend time and what they would wear. Where people had capacity to make specific decisions about their care they were consulted and involved.

Requires Improvement

# Is the service responsive?

## Our findings

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

People's needs were not always met.

Improving care quality in response to complaints or concerns

- People knew where to go if they wanted to raise concerns and we saw people had raised concerns and complaints. However, people did not feel their concerns were addressed appropriately.
- People told us they had raised concerns about the food and staff members but these were not addressed. We saw from feedback surveys and meeting minutes these concerns had been raised. We also saw relatives had raised issues with laundry and activities. We found none of these concerns had been addressed. Complaints were not managed in line with the complaints policy and an appropriate response had not been sent.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People told us there were insufficient leisure opportunities available to them. One person told us, "[There's] nothing to do. We're just here." Another person told us, "There's not a lot to do". This reflected our observations during the inspection where people spent most of their time sitting in the lounge with minimal interaction from care staff.
- We found some people's basic care needs were met appropriately. However, where people's dementia had advanced or they had developed additional health needs, people's needs were not fully understood and met effectively.
- People who had capacity to make decisions about their care had been involved in developing their care plans. Where people did not have capacity, we found an appropriate representative was involved and shared information about people's preferences and life history.

End of life care and support

- People's wishes at the end of their life had been discussed and considered. People's care plans contained information outlining their preferences.

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations have not been met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- Some people and relatives gave positive feedback about the culture within the service. There were also people within the service that told us they did not always feel heard or that action was taken when they expressed their wishes.
- Some care staff also gave positive feedback about the culture within the service while there were others that did not. We also saw examples of where care staff had raised concerns about the culture within the service that had not been fully explored and resolved.
- We found the provider had not ensured the management were open to exploring potential issues and concerns with openness and transparency in order to identify ways in which improvements within the service could be made.
- This formed part of a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and relatives were encouraged to share feedback about the service through forums such as meetings and quality feedback surveys. The registered manager had completed evaluations of these surveys although action had not been taken where areas of improvement were identified. Evaluations focussed on positive feedback and action had not been taken where concerns were raised about areas such as staff approach, food and laundry. As a result, improvements to the quality of service provided had not been made.
- Care staff told us action was not always taken when they raised concerns or suggested areas of improvement. We saw where staff had raised concerns in surveys, some meetings had been held to discuss concerns further. However, action was not taken to resolve the issues raised and to make improvements to the service. Where concerns included the approach of care staff, the failure to address issues appropriately led to the ongoing risk of poor care being provided to people.
- The registered manager's failure to ensure feedback was obtained and used to minimise risk and drive improvements formed part of a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

Continuous learning and improving care

- People were not protected by robust quality assurance systems that measured the quality of care provided and risk people were exposed to. We found regular audits and quality assurance checks were not

completed. For example; no checks had been completed around infection control within the current calendar year and this was an area in which we found improvements were required.

•□The provider and registered manager had not developed systems that identified the issues we found within the service. This included with people's nutritional needs, medicines administration, dignity and respect, the use of the Mental Capacity Act 2005 (MCA) and care provided not effectively meeting people's needs.

•□The provider and registered manager had failed to ensure where systems were developed they were effectively followed. For example; safe recruitment practices had been developed although these were not consistently applied.

•□The failure to develop effective audit and quality control systems formed part of a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

Working in partnership with others

•□The registered manager had had not ensured effective systems were in place to share information with agencies effectively in order to reduce risk to people and to improve the quality of care provided. For example; they had not ensured nutritional concerns were shared proactively with healthcare professionals and had not ensured safeguarding concerns were reported in a timely way.

•□The registered manager had however developed good relationships with people such as doctors, nurses and dieticians. Where the need for involvement was recognised the working relationships with others were positive.

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

•□The registered manager had a good knowledge of requirements such as information governance requirements. They understood the requirement to submit statutory notifications to CQC around significant events such as serious injuries and safeguarding concerns although they had not ensured this requirement was consistently met.

•□The provider acknowledged the issues that we identified during our inspection constructively and openly. They responded positively and made immediate steps to make improvements in the service.

•□We found notifications around allegations of potential abuse had not been submitted to CQC as required by law. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notifications of other incidents.

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 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The provider had not ensure people's dignity was upheld and they were consistently treated with respect. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider had not ensured they were consistently applying the requirements of the Mental Capacity Act 2005. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had not ensured they were identifying and managing risk to people effectively. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider had not ensured they had robust safeguarding systems in place to protect people from potential harm. |