Dr Rais Ahmed Rajput

# Wilnecote Rest Home

**Inspection report**

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Wilnecote,
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Date of inspection visit: 27 July 2015
Date of publication: 11/09/2015

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |
| Is the service safe? | Inadequate |
| Is the service effective? | Inadequate |
| Is the service caring? | Requires improvement |
| Is the service responsive? | Requires improvement |
| Is the service well-led? | Inadequate |

## Overall summary

This inspection took place on 27 July 2015 and was unannounced. Wilnecote Rest Home provides residential care for up to 23 older people. There were 16 people using the service at the time of the inspection some of whom were living with dementia.

There was a manager in post; however they were not yet registered with us to manage Wilnecote Rest Home. 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.

Risks to people's health and wellbeing were not consistently identified, managed and reviewed and people did not always receive their planned care. People were not always kept safe and their welfare and wellbeing was not consistently promoted.

# Summary of findings

People were not protected from the risk of abuse; some people had been abused by other people who used the service. Incidents were not identified as potential abuse; they were not reported or investigated.

Risk assessments and care plans did not reflect the current support and care needs of people. People were at risk of not receiving their prescribed medication when they needed it or in the correct way. Infection control was compromised by staff working practices. Some areas within the environment posed a risk of harm for people.

Some people who used the service were unable to make certain decisions about their care and treatment. The legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) were not being consistently followed. The MCA and DoLS set out the requirements that ensure where appropriate; decisions are made in people's best interests when they are unable to do this for themselves. People could not be assured that decisions were being made in their best interests when they were unable to make decisions for themselves.

Staff had a good knowledge of people's individual care needs but made assumptions on behalf of people in regard to choices and options.

People had access to healthcare professionals but did not always receive medical support and interventions in a timely way to ensure their health and well-being was upheld.

People told us the staff were kind, caring and helpful. However, some staff working practices compromised people's rights, privacy and dignity.

The provider had a complaints procedure and people told us they would speak with the manager or staff if they had concerns. The response and solutions to complaints were not made in a timely way.

The provider did not have effective systems in place to assess, monitor and improve the quality of care. Poor care was not being identified and rectified by the provider.

We found several breaches 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 overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC.

The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

# Summary of findings

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

We always ask the following five questions of services.

**Is the service safe?**
The service was not safe. Risks to people's health and wellbeing were not consistently identified, managed and reviewed. People's safety and welfare was not always promoted. People were at risk of and had been abused by other people who used the service. Incidents of abuse had not been recognised or reported. Care records relating to people's care and support needs were not always accurate or readily available. People were at risk of receiving unsuitable and unsafe care.

**Inadequate**

**Is the service effective?**
The service was not effective. The legal requirements of MCA and DoLS were not being followed. Decisions were being made by the manager and staff without due consideration or involvement of the relevant people. People experienced delays in receiving medical and health professional support when it was required. Staff did not always comply with the instructions given by health care professionals.

**Inadequate**

**Is the service caring?**
The service was not consistently caring. Staff were aware and knew the likes, dislikes and preferences of people. People were not offered choices and options because staff made assumptions on their behalf.

**Requires improvement**

**Is the service responsive?**
The service was not responsive to the needs of people. Staff were aware of people's changing care and support needs. Documents were not always completed in a timely way to record these changing needs. Recreational activities were available for people; however people's preferences and interests were not incorporated into the care and support plans.

**Requires improvement**

**Is the service well-led?**
The service was not well led. The manager in post was not registered with us to manage the home. Effective systems were not in place to assess, monitor and improve the quality of care. Poor care was not being identified and rectified by the manager or the provider.

**Inadequate**

# Wilnecote Rest Home

**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 was 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 27 July 2015 and was unannounced. The inspection team consisted of three inspectors.

We spoke with 15 people who used the service; some people were able to tell us their experience of life at the home. Some people were unable to, so we spent time in the lounge areas and observed the interactions between people.

We spoke with six people (relatives and friends) who visited the home, the manager, the deputy manager, four staff and a visiting health care professional. We looked at the care records of eight people and other records relating to the management of the service.

Inadequate

# Is the service safe?

## Our findings

Some people required support from staff to transfer to and from different areas within the home because of their mobility. We saw two staff used equipment to transfer a person from a wheelchair to an arm chair. Following this manoeuvre staff used an unsafe method to reposition the person in the arm chair. This was contrary to current moving and handling legislation and presents a risk of harm to the person. The person's moving and handling risk assessment was not clear as it did not specify the equipment to be used. The manager confirmed that not all moving and handling risk assessments had been completed or were up to date.

Another person required support with transferring; we saw they had sustained a leg injury when being supported by the staff. The district nurse had been contacted and visited the person to attend to the wound. It was recorded that 'staff should take more care when using the hoist'. There were no moving and handling plans within this person's care plans to provide documented guidance to staff in relation to the person's transfer requirements.

A person had been identified as at risk of choking, they had been seen by their doctor who had prescribed some thickener to be added to drinks to help with swallowing and reduce the risk of choking. We observed the person being supported with a beaker of unthickened orange squash. Two staff members confirmed that 'normal fluids' were given at times to help the person with swallowing. One staff member told us they knew they should not be doing this. The manager confirmed that additional support from a health care professional, for example a speech and language therapist, had not been made. This person was at risk of receiving unsafe and inconsistent care.

This is a breach of Regulation 9 and 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not always receive safe care and treatment.

Staff told us they had received training in safeguarding people from harm and told us they could recognise signs of abuse. They told us the different types of abuse for example, verbal, physical and financial. They went on to say they would report any concerns to the most senior person at the home. During the inspection we observed a person being hit over the head by another person. Staff did not recognise this altercation between these two people as an abusive situation. Staff commented as this was a regular occurrence between these two people they would not report this.

People who used the service were not safe and were at risk of abuse. Staff told us that some people relied on staff to support them with their own personal safety and well-being. It was recorded that staff had found one person in another person's bedroom. The person in bed had been disturbed and had been found with their pillow removed, duvet cover disturbed and their personal items strewn around their room. Staff told us the person was living with dementia and would be unable to call for help when they were in their bedroom. They were unable to tell us if any action had been taken to support the person with their safety. This meant this person was not being protected from the risk of abuse.

This is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always protected from abuse.

Some people were at risk of developing sore skin due to frailty or immobility and had been prescribed creams, lotions and ointments. Staff told us they applied these at the time of providing personal care to people. They did not sign any record to indicate they have completed this task. We saw external medications (creams and lotions) that had been prescribed for people were being used and applied on other people. People were at risk of receiving external medications for which they were not prescribed and inconsistent with the prescribing instructions.

Some people required medication that can be given on an 'as required' basis. Staff confirmed there were no protocols or specific guidance for staff as to when, how often or why the medication could be given. People were at risk of not receiving their prescribed medication when they needed it.

Some medications needed two members of staff to administer and to sign a register to indicate that the medication had been given correctly. These medications were recorded in the register, however we saw that on two occasions only one staff member had signed the register when the medication had been administered. This was contrary to current guidance to ensure people received their medication safely.

We saw sluice rooms were in several areas around the home, and in one we saw that a commode pot contained

Inadequate

# Is the service safe?

urine. Staff were unable to tell us who provided the urine sample, how long this had been there or when it was to be disposed of. Staff were unable to tell us how the commodes pots were effectively cleaned after use. One staff member told us that the 'cleaners' attended to this task. We were informed that there were no 'cleaners' at the service at the time of this inspection.

Some people required staff to support them with their personal care. There were no hand wash facilities for staff to use in the bedrooms. For the effective control of the spread of infections suitable hand wash facilities should be provided at the point of the delivery of care. We saw care staff walked around areas of the building wearing disposable gloves prior to and after supporting people with their personal care. This posed an infection control risk as staff were not using or disposing of the gloves in the correct way.

We saw care staff walked through the main kitchen area to access the staff toilet. One member of staff told us that this shouldn't happen and that an alternative route should be used. We saw cleaning equipment for example mops and buckets in a dirty state, these were stored in the toilets. There was no indication of the areas that the mops were being used or how to effectively clean the equipment. Infection control was compromised due to staff practices.

This is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified areas of concern in relation to the premises and equipment at the home. We saw that call bells were out of reach for some people so they would not be able to call for help when they required support. A call bell cord was tied out of reach in a toilet and bathroom, again in the case of an emergency people would not be able to attract the attention of staff when they required help. We saw that people were sat next to a broken radiator cover in the dining area. These people were at risk of injury due to the sharpness of the broken metal cover. Suitable light fittings were not fixed and fitted in some bathrooms and the extractor fans in bathrooms and toilets without natural ventilation were not working. We spoke with the manager who confirmed they were aware of some of the concerns we identified but no action had been taken.

This is a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the records of three staff members to check that the home's recruitment procedure was effective and safe. References for one person had not been obtained prior to them starting work at the home. The provider told us this person had worked at the home for a long period of time and as such references had not been applied for. Criminal record bureau (CRB) checks were in each of the three files and dated at the beginning of their employment. These checks (and the current Disclosure and Barring Service (DBS) show whether people have been convicted of an offence or barred from working with vulnerable adults. The manager told us that many of the staff were long time employees. Systems and checks were not in place to ensure staff continued to be of sufficiently good character to provide care and support.

People and their relatives and friends told us there were sufficient staff available to help and support them with their care needs. They told us they did not have to wait too long before staff were available to help them. We did not observe any delays when people requested help. The care staff told us they regularly checked and visited people who spent the majority of their time in their bedrooms.

Inadequate

# Is the service effective?

## Our findings

People were not always involved in decisions about their care and treatment. The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) set out the requirements that ensure where applicable, decisions were made in people's best interests when they were unable to do this for themselves. Some people who used the service were living with dementia and at times found it difficult to make informed decisions about their care and treatment. No capacity assessments had been completed to establish a person's decision making abilities and best interest decisions were being made by the manager and staff. For example a decision had been made for a person to spend the majority of their time in their bedroom. The decision had been made without due consideration or involvement of the person or relevant people who may be acting on their behalf.

This is in breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always consulted and consent was not always sought legally when people did not have the capacity to make informed decisions.

Most people who used the service were subject to continuous supervision and control and lacked the option of leaving the home. This course of action may result in people's freedom being restricted. The manager told us there were occasions when one person wanted to go out in the evening. They told us that for the safety of the person they could not go out alone. The manager confirmed that some DoLs referrals had been sent to the local authority for consideration and authorisation. None had been returned to legally authorise restrictions. No records or care plans were available to show how the manager was providing care in the least restrictive way. This course of action may result in people's freedom being restricted. The provider was not working in accordance with the MCA and DoLS.

This is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received a range of training, and they could request additional training if they felt a need to do so. Staff told us they needed more training in MCA and DoLS to gain a deeper understanding of the implications of this legislation.

Some training was provided externally and some provided by an in house trainer. Some staff had received training in dementia awareness and we saw good interactions between staff and people who were living with dementia. Staff had received training in how to support people to move safely, however we observed some unsafe practices with the use of the hoist and positioning of people in their chair.

People told us they enjoyed the food. One person told us the food provided: "Was always a surprise". Another person said: "The food is nice and they bring extra drinks if we want them". A relative said: "The meals seem good, my relative doesn't complain". We observed the lunchtime meal. There was a set menu and we saw the staff made assumptions about people's preferences. People were not offered a choice of meals or drink options, staff did not ask people what they wanted to eat and drink, plates and tumblers were placed on the table in front of the person. People requiring a soft diet received this with all the food items pureed together, which did not allow for a food preference or for any discussion about the meal. During the afternoon people were offered fruit. One person was offered an apple but they just looked at it until a visitor requested for the apple to be cut up. Another person was given a whole banana to hold, there was no plate or an offer for it to be cut up. This demonstrated the staff did not consider people's individual support requirements.

We saw contact was made with health professionals when needed, we saw referrals being made to various departments, however these were not always followed up in a timely manner. For example, a request for a blood test relating to a person's weight loss had not been completed a month after the request was made. One person was at risk of choking, staff confirmed that a referral had not been made to a dietician or speech and language therapist to provide guidance to reduce the risk to the person.

Requires improvement

# Is the service caring?

## Our findings

Staff told us they had worked with people for a period of time and as such were very familiar with people's care and support needs, their likes and dislikes. We saw many examples where staff made assumptions regarding people's choices and options. People were not always given the opportunity to choose and make decisions for themselves. We observed a member of staff placed a blue plastic apron over a person's head without any communication or consent for them to do so. This demonstrated people's dignity was not always considered.

Some people who used the service were living with dementia and at times would become disorientated in time and space. Consideration to people's sensory needs had not been made to ensure people could find their way around the home independently. There were no vacant/ engaged signs on bathroom and toilet doors to indicate that the facilities were free to use. People's privacy may be compromised when using the facilities due to the lack of suitable signs.

People's relatives and friends told us they could visit at any time. One visitor we spoke with said they felt welcome within the home and went on to say: "At Christmas I was invited to stay for a meal and the residents had a fantastic time with games and celebrations". A person who used the service told us they really enjoyed visits from their family and friends.

People told us the staff were kind, caring and helpful. We saw staff interacted with people in a pleasant and friendly way. We observed a staff member engaged in a conversation about a recent family visit and some new items of clothing that had been purchased on behalf of their relative. Interactions between the visitor and staff were good with the staff showing a great interest in the purchases.

Staff told us and we saw people were supported to their private bedrooms when visited by the district nurses or doctors so that the consultations could take place in private.

Requires improvement

# Is the service responsive?

## Our findings

Staff told us that most of the care staff had been working at the home for many years and they relied on their own knowledge about people's care needs. One staff member said: "We know how to care for [a person who used the service] they have been here for years". They told us about this person's care and support needs and how their needs had changed over a period of time. Staff told us when people's care needs had changed; they were made aware of these changes at staff handover. We saw documentation relating to the handovers, however there were gaps where some days had been missed; this meant important changes could have been overlooked.

For example some people were at risk of becoming unwell. There was no information to support staff with their current care and support needs so people were at risk of receiving inappropriate care. People's care records were out of date and did not reflect the care they required. The care was not planned and delivered in a person centred way and people were at risk of receiving inconsistent and unreliable care.

The home had an activities coordinator who was on leave on the day of our inspection. Care staff were supporting people with some recreation in addition to attending to their care duties. We observed some music entertainment and some people playing dominoes. Relatives told us that there were activities at the home. They told us: "They have singers, craft days and they played armchair ball games". We also observed a poster of a forthcoming summer fair at the home. However there was no indication that people's preferences and interests were incorporated into their care and support plans. This meant people may not be consistently supported to participate in activities that were meaningful or suitable with their needs and preferences.

People told us they had not been asked about the home environment or given an opportunity for them to express any complaints. Relatives we spoke with felt they could approach the management about any concerns. We saw no records in relation to meetings involving the people or their relatives. The manager told us that complaints were investigated using the provider's complaint procedure. We saw a record which detailed a complaint by a relative. The actions required to resolve the complaint and improve the care provided were not completed. The manager could not demonstrate that improvements were made in response to complaints in a timely way.

Inadequate

# Is the service well-led?

## Our findings

People and their relatives had not been involved in discussions about their likes and dislikes or what was important to them. The plans were not personalised and not all sections had been completed, including any changes that were identified. For example staff told us of a specific treatment that one person required to reduce the risk of harm. A different treatment was recorded in the care plan for this person. Staff were not aware of the changes, and confirmed that care plans were not all up to date. The manager told us that care plans were reviewed each month. We saw that the plans were being reviewed but they did not reflect the current care and support needs of people who used the service. People were at risk of receiving inconsistent and unreliable care and support.

Risks to people were not being consistently identified, managed and reviewed by the manager or provider. Some people's welfare and safety was not promoted and their current care needs not taken into consideration. For example, some people had an identified weight loss where monitoring and food supplements were required. There was inconsistent recording of when the food supplements were to be offered and variable monitoring of dietary intake. Some people would need assistance with vacating the premises in the event of an emergency. The manager told us that personal emergency evacuation plans were currently unavailable but they were on their 'to do list'.

The manager had not raised safeguarding referrals with the local authority when there had been incidents of abuse. We saw incidences where people were at risk of harm and were being assaulted by other people. Investigations were not carried out to reduce the risks to people because the staff, the manager or the provider did not recognise the need to do so. People were at risk of and had been abused by other people who used the service.

The manager, the provider and the managers from the provider's other two homes met each week to discuss issues. The manager told us they could request additional equipment and any staff requirements at these meetings and that generally they were provided. We met with the provider to discuss our concerns and including a section of the environment which was poor. They agreed with our findings but took no positive action to remedy the situation. People continued to be accommodated in a physical environment that did not offer a quality of life or promote their well-being.

These issues constituted a breach in Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The service does not have a registered manager; however since May 2015 a senior member from another home belonging to the provider had taken over the role as manager. Staff told us they felt well supported by the manager and they worked well as a team.

The manager confirmed there were some quality monitoring systems in place but these were 'limited'. They confirmed they were unable to establish if any systems were in place prior to their appointment and that very few documents were available to them. The manager told us of the plans to further develop the systems so that they could be assured the home would operate safely.

Satisfaction surveys had been sent to relatives of people who used the service. The responses were mainly positive in regard to the food, the staff and the environment. The manager planned to hold a resident /relative meeting in August 2015 in an attempt to obtain the views of people who used the service.

This section is primarily information for the provider

# Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>The care and treatment to service users was not appropriate, met their needs or reflected their preferences. |

**The enforcement action we took:**
The service was placed into special measures and an urgent notice of decision was served on the provider to suspend all new admissions into the service.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>Care and treatment of service users must only be provided with the consent of the relevant person. If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act. |

**The enforcement action we took:**
The service was placed into special measures and an urgent notice of decision was served on the provider to suspend all new admissions into the service.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Care and treatment was not provided in a safe way. |

**The enforcement action we took:**
The service was placed into special measures and an urgent notice of decision was served on the provider to suspend all new admissions into the service.

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Enforcement actions

| 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>Service users were not safeguarded from abuse and improper treatment. |

**The enforcement action we took:**
The service was placed into special measures and an urgent notice of decision was served on the provider to suspend all new admissions into the service.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br><br>All premises and equipment used by the service provider must be suitable for the purpose for which they are being used, properly used and properly maintained |

**The enforcement action we took:**
The service was placed into special measures and an urgent notice of decision was served on the provider to suspend all new admissions into the service.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>Systems were not established and operated effectively to ensure compliance with the requirements. |

**The enforcement action we took:**
The service was placed into special measures and an urgent notice of decision was served on the provider to suspend all new admissions into the service.