

Wilson Care Resources Limited

Wilson Lodge

Inspection report

16 Augusta Road East
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Tel: 01214491841

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07 June 2017

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 30 November and 01 December 2016. Breaches of legal requirements were found. After the comprehensive inspection, the provider developed an action plan to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. We found that they had not met the legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk.

The home is registered to provide personal and nursing care with accommodation for up to 36 people who have needs relating to their mental health. At the time of our inspection there were 26 people living at the home. The home has a registered manager and they were present throughout our inspection. 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.

People we spoke with did not all feel safe at Wilson Lodge. People shared examples with us of times they had felt scared or when their personal belongings had been taken. The registered manager's initial response to these concerns was not robust to protect people using the service. Since our inspection we have been informed action has been taken.

Although parts of the home had been redecorated to reflect people's tastes and choices, people did not always live in a safe or clean environment. The work undertaken to ensure that bathrooms were clean, free from odour and that the floors protected people from the risk of slipping and falling had not been adequate. Specific tests and examinations of the passenger lift and other equipment, including the supported bath were not all completed as required by lifting regulations.

Some areas of the home had been re-decorated and we saw these areas appeared improved. Some bedrooms had been redecorated and the work completed reflected people's tastes and choices.

The governance systems in place had not been fully effective at achieving the improvements required. Improvements were needed to the cleanliness, comfort and safety of the premises, and to ensure systems that would monitor the safety and quality of the service were in place and being effective. Actions the registered provider told us they would take had not all been undertaken. The registered provider's action plan relating to these areas had not been kept under review and updated as required. The plans and improvements made by the registered provider and the registered manager's employed over that period have not resulted in adequate, timely or sustained changes to ensure people's safety at Wilson Lodge.

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?

Action had not been taken to address safety concerns.

People had not been provided with a safe, comfortable or clean home in which to live.

People did not always feel safe, and the response to people's feelings and information of concern was not robust.

Requires Improvement ●

Is the service well-led?

Action had not been taken to improve leadership and governance.

The systems to assess, monitor and improve the service had been ineffective.

Requires Improvement ●

Wilson Lodge

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Wilson Lodge on 06 June 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 30 November and 01 December 2016 had been made. The team inspected the service against two of the five questions we ask about services: Is the service Safe and Is the service Well led? This is because the service was not meeting some legal requirements. The inspection was undertaken by two inspectors.

Before the inspection visit we reviewed all the information we held about the service. As part of the inspection we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care. We refer to these as notifications. We reviewed the information from notifications to help us determine the areas we wanted to focus our inspection on. After our last comprehensive inspection the registered provider produced an action plan. We also looked at this to help inform our inspection planning.

We visited the home and met most of the people living there. Some of the people living at the home were not able to speak with us. We spent time in communal areas observing how care was delivered and we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During our inspection we spoke with two care staff, one nurse, a member of the maintenance team, the registered provider and the registered manager. We looked at parts of three people's care plans. We looked at the premises and the records to show checks and services of the facilities provided. We looked at the checks and audits undertaken by the registered manager and registered provider to ensure the service provided was meeting people's needs and the requirements of the law.

Is the service safe?

Our findings

People we spoke with did not all feel safe at Wilson Lodge. People shared with us examples of when they had felt frightened or had been harmed during their time at the home. We observed that people were at ease and comfortable around staff, however we identified periods of time when staff were not delegated to communal areas of the home to ensure people remained safe. On some of these occasions, we observed that some people spoke aggressively to one another, and made allegations about how other people had treated them at the home. There were no staff available to observe this, to provide support or reassurance to either person.

We explored these concerns with the registered manager. We saw that some people's care plans and risk assessments reflected the risks of people making such allegations and of people being vulnerable to allegations from others, and making allegations themselves. The registered manager described some of the circumstances that could have led to these allegations being made. However the action taken when the allegations were brought to their attention did not ensure these matters were explored further, that people got the support they required on having raised information of concern, or that the relevant notifications would be made in these instances as is legally required. Following the inspection we received information that showed the improvements the registered manager had made in response to our feedback.

Some people told us that they did not have keys to lock their bedrooms. They told us they would like a key and people gave us examples of when they had felt unsafe in their bedroom or when their possessions had been taken as their door was unlocked. We explored this with the registered manager. The registered manager was unable to provide reasonable explanations for each person regarding this. The arrangements to protect people's privacy and their property were not effective and did not meet people's needs and wishes.

We found that allegations of abuse and matters of a safeguarding nature had not been routinely identified. The registered manager and registered provider had failed to ensure that the staff team would recognise and report possible allegations of abuse. They had not always identified possible allegations of abuse and reported these themselves. There were no robust procedures or processes in place to ensure people were protected. Ensuring people were safe had not received the scrutiny or oversight required from the registered manager or registered provider. Failing to protect people from abuse and failing to have systems in place that will identify and ensure abuse is reported is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Other people we spoke with told us they did feel safe, and feedback included, "The staff do look after you well," and "I feel safe. There are no problems."

At our last two inspections, we found on-going concerns in respect of the premises of the home and found that the registered provider was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people did not live in premises that were clean and well maintained. At this inspection, we found that the planned work to ensure the safety of the

premises, equipment and facilities had not been adequate. At this inspection, we found that the registered provider had failed to complete the work required and this regulation had not been met.

The work undertaken to ensure that bathrooms were clean, free from odour and that the floors protected people from slipping and the risk of falls had not been adequate. The design of the bathrooms and the cleaning undertaken did not ensure these facilities were clean and free from offensive odours. At our last inspection we identified that the flooring used in some bathrooms became very slippery when wet. People had fallen over and hurt themselves. In response to this the registered provider told us of the action they would take. The bathrooms where non slip matting had been fitted had not been effectively cleaned and we saw a build-up of residue under the mats. The cleaning schedule in place was not adequate to keep this area clean or pleasant for people to use. In one bathroom the non-slip matting had not been securely fitted. We observed that it was curled up and presented people with a trip hazard. At this inspection the provider was unable to produce evidence that the required process to make the other floors safe, had been undertaken with the frequency required to maintain a safe, non-slip surface. Although there had been no new falls reported, there was a significant risk of falls occurring again. The floor and system in place to maintain it did not adequately protect people from this risk.

People could not be confident that the tiling and flooring provided in bathrooms would be consistent with best infection control practice. The registered provider advised us that new laundry facilities were to be developed. While this development was positive, it was of concern that advice had not been sought from specialist advisors to ensure this would be safe and reflective of best infection control and laundry practice.

Records were not available to show that the passenger lift and other weight bearing equipment, had all been serviced or inspected as was required. We had brought this same matter to the attention of the registered provider at our last inspection up to six months ago. The registered manager informed us that a date had been made for these tests the following week. Timely action had not been taken to ensure us that equipment was safe and fit for use.

The premises and equipment were not all clean, secure and safe. This is a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service well-led?

Our findings

At our last two inspections, we identified on-going concerns in respect of the governance and leadership of the service. We found that the registered provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people did not benefit from a service that was continually looking to improve the quality and safety of the service provided. At this inspection, we found that whilst the registered provider and registered manager had made efforts to improve the service, these improvements had not been effective. The service was still not meeting regulations, ensuring people were safe or consistently meeting people's needs.

We looked at a range of audits and checks undertaken by the registered manager and provider regarding the operation of the home. These had not been undertaken systematically to routinely consider all areas of the home's operation and people's experience. Where some of the audits and checks we reviewed had identified matters that required improvement, action had not been taken to address these areas of improvement. This meant people did not consistently see positive changes as a result of their feedback, or experiences. These audits had not all been re-visited to ensure the required changes had been made. Our inspection of the premises identified matters that had previously been identified in an audit undertaken by the registered provider in April 2016. It was not evident that the required action had been taken. We also identified long standing issues that had not been identified in any audits. This included an unguarded hot water pipe that ran close to a level access shower in one bathroom. The pipe was at a height where people could burn their foot or ankle if they came into contact with it. We brought this to the attention of the registered provider who had never previously identified this as a risk and had therefore taken no action to improve this.

There was evidence that the systems in place to ensure the service operated effectively and is compliant with the regulations were not effective. The plans and improvements made by the registered provider and the registered managers employed have not resulted in adequate, timely or sustained changes. The action plan developed in response to our visit in November 2016 had not been effective. Actions the registered provider told us they would take had not all been undertaken. The plan had not been kept under review and updated as required.

Throughout our inspection we saw that staff did not promote people's independence and choice and on occasions some staff practice did not value people, or promote their dignity or safety. On some occasions these interactions were witnessed by senior staff, who failed to challenge the practice. We shared concerns with the registered manager that some senior staff had witnessed poor staff interactions between staff and people but they had failed to make a timely or proportionate response to address these issues and to ensure that consistent good standards of support were always provided. The culture of the home failed to challenge poor practice or to provide staff with alternative more appropriate ways of supporting people and working.

The overall leadership and governance of the home had failed to ensure that work was undertaken systematically, in line with good practice guidelines and kept under review to ensure progress was timely

and in keeping with the action plan. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In March 2017, a survey of people using the service, their relatives and staff had been undertaken by the registered manager. The results had been compiled into a report and showed the feedback from people regards aspects of the service people liked and where they thought improvement was required. The registered manager was able to give examples of the work undertaken to address these suggestions.

The registered manager informed us that it was her intention to develop a continuous improvement plan. Developing such a tool would help assess, monitor and drive forward improvement within the home.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment
Treatment of disease, disorder or injury	Ensuring people were safe had not received the scrutiny or oversight required from the registered manager or registered provider. Failing to protect people from abuse and failing to have systems in place that will identify and ensure abuse is reported is a breach of regulation

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 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	The premises and equipment were not all clean, secure and safe.

The enforcement action we took:

We issued a warning notice requiring the registered provider and registered manager to become compliant by a set time.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The leadership and governance of the home had failed to ensure that work was undertaken systematically, in line with good practice guidelines and kept under review to ensure progress was timely and in keeping with the action plan.

The enforcement action we took:

We issued a warning notice requiring the registered provider and registered manager to become compliant by a set time.