

Wellesley House Nursing Home Limited

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Inspection report

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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

About the service

Wellesley House Nursing Home Limited is a care home providing personal care to 25 people at the time of the inspection. The home is registered for up to 38 people. People have access to their own bedroom along with communal spaces including lounges and gardens.

People's experience of using this service and what we found

Quality checks in place to monitor the home were not consistently completed. When completed they did not always identify areas of improvement or demonstrate the actions taken. The provider could not always demonstrate when things had gone wrong, and lessons learnt.

There were no systems in place to work out staffing levels in the home. Despite this, people felt safe and felt their needs were met. Further improvements were needed to ensure people had 'as required' medicines plans in place when needed.

Risks to people were considered and reviewed, when needed. Infection control procedures were in place and followed. People received their medicines when needed and were happy living in the home.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update

The last rating for this service was requires improvement (Published 17 March 2020).

Why we inspected

We received concerns in relation to safety and leadership. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wellesley House Nursing Home Limited 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 how the home is governed.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe.
Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.
Details are in our safe findings below.

Requires Improvement ●

Wellesley House Nursing Home Limited

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 Health and Social Care Act 2008.

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

The inspection was carried out by 1 inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Wellesley House Nursing Home Limited 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.

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was a registered manager in post. However, they are no longer working in the service. We discussed this with the nominated individual who offered us assurances they were ensure this registration was corrected and the relevant notification submitted.

There is a new manager in the home who intends to register with us, we will assess the application when received

Notice of inspection

The inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since our last inspection, including notifications the provider had sent to us. We also gathered feedback from the local authority. 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 used all of this information to plan our inspection.

During the inspection

We spoke with 7 people who lived at the home and 1 relative. We also spoke with the nominated individual, a member of the administrative staff, 2 registered nurses, a member of the kitchen staff and 3 care staff. We looked at the care records for 5 people and 20 medicines records for people living in the home. We checked the care people received matched the information in their records. We looked at records relating to the management of the service, including audits and recruitment checks carried out within service. The nominated individual is responsible for supervising the management of the service on behalf of the provider.



Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. 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.

Staff and recruitment

- People told us there were enough staff and they did not have to wait for support. One person said, "The staff check me regularly and I have a call bell if I need them, they come quite quickly". Another person told us, "There are enough staff on duty. I can walk around with my walker, but if I need them to come to me, I can press the buzzer, they come in enough time".
- Although people did not have to wait for support and their needs were met, we observed some of the support people received was task led and there were limited interactions between staff and people.
- It was unclear how staffing levels were calculated within the home. We saw people's dependency levels were in their files, however there was no system to ensure this information was then used. Staff we spoke with told us staffing levels were worked out on the amount of people in the home and not the needs of individuals.
- Staff had received the relevant pre-employment checks, including references and Disclosure and Barring Service (DBS) checks before they could start working in the home to ensure they were safe to do so. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

- Improvements were needed as when people were prescribed 'as required' medicines there were not always protocols in place to ensure staff had the information to administer these medicines when people needed them. The nurses we spoke with knew people well and when to administer these medicines to people.
- People told us they received their medicines as prescribed, and we saw these were administered to people in a safe way. One person said, "I have my tablets given to me by a nurse, I'm not sure what the tablets are for, but they come at breakfast and dinner time every day".
- Staff administering medicines had completed training and a competency check to ensure they were safe to administer medicines.

Learning lessons when things go wrong

- There was some evidence to demonstrate lessons had been learnt when things went wrong. For example, when safeguarding incidents had occurred these had been reviewed. Improvements were needed to ensure this covered all areas including when incidents had occurred and throughout the governance systems that were in place.

At our last inspection the provider had failed to ensure risks to people were fully considered.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

Assessing risk, safety monitoring and management

- People felt safe living in the home. One person said, "I like it here, I am happy and feel well protected, the doors are secure, and the staff support me using a hoist to sit in my recliner chair, which stops me from falling out." Relatives raised no concerns over people's safety.
- Risks to people were now assessed, monitored and reviewed and when needed individual care plans were in place. Care plans in place included, the management of diabetes, pressure relief and moving and handling. These plans were detailed, and staff were able to use this information to ensure people were supported in a safe way.
- When people were at risk of developing sore skin or dehydration, charts were in place that recorded how people were supported to keep safe. For example, where people required 2 hourly repositioning to help prevent them from developing sore skin, records confirmed people received this. The nurses also monitored this as part of their daily checks to ensure this had been completed.

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 MCA 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 when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Systems and processes to safeguard people from the risk of abuse

- People were protected from abuse as staff knew how to report and recognise when people may be at risk. Staff we spoke with said they would document their concerns and raise with the manager.
- Procedures in place were followed to ensure people were protected from potential abuse.
- Staff also confirmed they had received up to date training in safeguarding people from abuse.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the

premises.

- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

- There were no restriction placed on visiting and visitors could access the home freely, in line with current government guidance.

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 our last inspection we rated this key question requires improvement. The rating for 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 had failed to demonstrate good governance. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Quality checks and audits were inconsistently completed in the service. Although the nurse completed a daily check of people's care, including medicines management and reviews of care, this information was not always analysed or used to drive improvements. We found no concerns with the care people received and these checks ensured people were supported as needed.
- Where infection control and environmental audits had been completed in the home, actions taken to address the concerns identified had not always been documented so although we saw some actions had been addressed, we could not be assured that all actions had been addressed.
- The audits and checks that were completed within the home had not identified that people did not have 'as required' protocols in place. This placed people at risk of not receiving these medicines when needed.
- Although we saw there were enough staff available for people, at our last inspection we raised concerns with how staffing levels were worked out, the provider had not taken prompt action to consider or resolve this. This meant we could not be assured that staffing levels would always be appropriate to meet people's needs.
- Feedback was sought from people who used the service; however, this was inconsistent, and it was unclear how this information was used to make changes. We saw some surveys had been completed and the feedback received was positive. The provider told us they would collate this information and feedback to the people living in the home.

The systems in place were not effective in identifying areas of improvement. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff attended supervisions and team meetings so that they could share their views. Staff felt supported and listened to by the manager and provider and spoke positively about the home.
- We had been notified about events that had happened within the service when needed.

- Staff understood their roles and responsibilities and there were clear lines of delegation.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Some improvements were needed to ensure people always received care in a person-centred way. For example, there was an emphasis on completing tasks for people and not with them and there were set routines that were followed.
- People liked the home and living there. One person said, "I don't think there need to be any improvements made at the home".
- Staff worked closely with people to ensure they received good outcomes in relation to their health.

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

- Duty of candour requirements were understood and met.
- Since our last inspection the manager and provider had been open and honest with people and their relatives and ensured they were notified of events accordingly.

Working in partnership with others

- The service worked closely with other agencies to ensure people received the care they needed.