Wythall Residential Home Limited

Wythall Residential Home

Inspection report

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Date of inspection visit:
27 July 2022
28 July 2022

Date of publication:
22 November 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Wythall Residential Home is a residential care home providing accommodation for persons who require nursing or personal care for up to 22 people. The service provides support to older people. At the time of our inspection there were 17 people using the service.

Wythall Residential Home accommodates people in one adapted building.

People's experience of using this service and what we found
We found no evidence of harm to people but systems to manage people's risks required further development and to be embedded into staff practice. Improvements needed to be made in how people's medicines were stored, administered and managed, so people always had these as prescribed. Potential safeguarding concerns needed to be consistently managed and appropriate action taken to inform Local Authority safeguarding teams and The Care Quality Commission when such incidents occurred. People's assessments needed to be consistently updated when their needs changed.

There had been multiple changes to the staff running the home and a manager was not registered with The Care Quality Commission, as legally required. Where checks on the quality of care had been undertaken by the provider these were not effective in making improvements to the care people received.

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 in the service supported this practice. However, the systems to ensure people's rights were consistently promoted required further development. This was required to ensure staff knew which people had a DoLS authorised and these were promptly notified to The Care Quality Commission.

Some people had enjoyed improved help since moving to the home, but we found action was not always promptly taken to seek advice from people's GPs or health specialists. People and relatives told us staff had the skills to care for people. However, staff's induction records did not evidence they had completed the full range of the provider's induction training.

Some people's health and care needs assessments were not always updated as their needs changed. Areas of premises management required further development, to reduce risks to people further.

The provider had started a programme of premises improvements, to increase the number of rooms with ensuite facilities. There were enough staff to care for people, and people did not have to wait long if they wanted assistance from staff. There were no restrictions on visiting arrangements and staff took action to reduce the likelihood of the spread of infections.

Rating at last inspection and update

The last rating for this service was requires improvement (published 8 June 2019) and there were breaches of regulation relating to people's safety and how the service was managed. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

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

Why we inspected
The inspection was prompted in part due to concerns received about people's safety and the management of the service. We also wanted assurances following our inspection of the home on 2 May 2019 that the provider had followed their action plan, and legal requirements were now met. As a result, we undertook a focused inspection to review the key questions Safe, Effective and Well-led which contain those requirements.

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

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We have found evidence that the provider needs to make improvements, to reduce the risk of harm to people further. Please see the Safe, Effective and Well-led sections of this full report.

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 monitor the service and will take further action if needed.

We have identified breaches in relation to the management of people's safety, how people are protected from the risk of abuse and how the service is managed at this inspection.

You can see what action we have asked the provider to take at the end of this full report. The provider began to take action to address identified concerns during the inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wythall Residential Home on our website at www.cqc.org.uk.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect. We will also request an action plan from the provider to understand what they will do to improve the standards of quality and safety.

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Wythall Residential Home

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.

Inspection team
The inspection was undertaken by two inspectors.

Service and service type
Wythall Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Wythall Residential Home is a care home without nursing care. 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 not a registered manager in post.

Notice of inspection
The first day of the inspection was unannounced. On the first day of the inspection we announced our intention to continue the inspection at Wythall Residential Home for a second day.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they

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

During the inspection
We spoke with six people who used the service and five relatives about their experience of the care provided.

We spoke with nine members of staff including three provider's representatives, senior and support staff.

We reviewed a range of records. This included five people's care records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including incidents and accidents, safeguarding, audits, compliments and policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At 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.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to always protect people from the risk of abuse, in line with their responsibilities to safeguard people from harm.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● People were not consistently protected from the risk of abuse. On three separate occasions during June 2022 and July 2022 a person had sustained unexplained bruising to their skin and on one occasion a cut to their jaw. The provider's representative confirmed staff had failed to escalate these concerns and the provider's checks had failed to identify these as potential safeguarding concerns. The provider had not notified The Care Quality Commission, or made a referral to the local authority safeguarding team in line with their responsibilities to safeguard people from harm.

Systems had not been established and operated effectively to prevent abuse of service users and investigate evidence of abuse. This placed people at risk of harm. This was a continued breach of regulation 13 (2), (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They started investigating these concerns, referred them to the local authority safeguarding team and notified The Care Quality Commission.

Using medicines safely

● People did not always benefit from support to have their medicines administered safely. For example, where people were prescribed pain relief patches regular checks were not made to ensure these remained in place. In addition, there was no record that the site of administration of the patches was varied, as prescribed. This increased the risk of people not receiving the pain relief they required and may experience poor skin health.

● Some people's medicines needed to be stored at specific temperatures. The provider had recently introduced systems to support staff to check people's medicines were stored within the correct temperature ranges. However, the systems were not effective, and we could not be assured people's creams, (topical medicines), were stored safely. This increased the risk people's medicines may not be effective and increased the risk of poor skin health.

● The date topical medicines had been opened had not been consistently recorded. It was therefore unclear if people's medicine was being used within the recommended timescales.
● Medicine audits and checks had recently been introduced but did not include checks on the administration of prescribed topical medicines. This meant some of the issues we found had not been identified by the provider.
● We discussed these concerns with the provider's representative who assured us they would take immediate action to address these concerns, to reduce the risk to people further.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● People's needs had been assessed but risks to their safety were not consistently monitored and managed. This included in relation to people's bowel health and weight loss.
● Staff were not always provided with the guidance they needed to support people safely where they required a specific texture of food, to reduce the likelihood of them choking. Where people required specialist advice from other health professionals such as speech and language therapists the provider's lack of oversight meant this was not always promptly followed up.
● Improvements were required in the way the premises were managed, in order to reduce risks to people. On the first and second day of the inspection food intended for consumption by people at the home was stored outside of "use by" dates. Toiletries were left in a communal bathroom/hairdressing salon where they were accessible to people who may be at risk of ingesting them. We asked for these items to be removed, but they remained in place on the second day of the inspection. This increased the risk people may experience ill health or harm.
● People's assessments were not consistently updated as their needs changed. For example, one person's mobility had significantly deteriorated, but their personal emergency evacuation plan had not been updated to reflect they would need extra support in the event of a fire occurring.
● The provider missed opportunities to learn lesson when things went wrong as people safety needs were not consistently reviewed after accidents or incidents. Action was not always taken to mitigate people's risks.

We found no evidence of harm to people, but systems were either not in place or robust enough to demonstrate safety was effectively managed, concerns promptly identified and risk to people swiftly mitigated. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider started to respond to these concerns during and after the inspection.

● People's relatives told us they were consulted about their family member's safety and felt their suggestions were listened to. Some relatives gave us examples showing how their family member's safety and well-being had improved since moving to the home.
● Staff told us they were provided with the information they needed about people's safety and care needs at meetings at the start and end of their shifts.

Staffing and recruitment
● We saw people did not wait long for staff to support them and there were enough staff to meet people's safety and care needs.
● Staff told us there had been times when they covered additional shifts, owing to staff vacancies, but told us this situation was improving. One staff member said, "I don't feel [late shifts] have enough staff. Staff also have to do the laundry and hoisting. People are more agitated at this time, but there would not be too much of a delay if [people] wanted help if they were upset. It does feel better than a couple of months ago."

● Staff were recruited safely. Checks had been completed prior to staff starting their employment at the home. These included references and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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.
● There were no restrictions on visiting arrangements and people's friends and family were able to visit in line with current guidance.

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.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 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 MCA.

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 appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Staff providing care to people did not know who had a DoLS authorised. This increased the risk people may be unlawfully deprived of their liberty.
- The Care Quality Commission had not always been informed prior to our inspection where the supervisory body had authorised DoLS.
- The provider's representative acknowledged further development of systems and processes were required to ensure people's rights were consistently promoted.
- After the inspection the provider's representative sought additional training for staff and notified The Care Quality Commission of approved DoLS authorisations.
- People's consent to care and treatment had not always been documented. However, we found staff did involve people in decisions about their support, when providing their daily care.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
- We found where people experienced weight loss action was not always promptly taken to seek advice from people's GPs. In addition, we also saw staff had not always promptly advocated for people requiring support from health specialists. For example, speech and language therapists. This increased the risk people

would be ill for extended periods of time.
● We discussed these concerns with the provider's representative, who took immediate action to address them.
● People were confident staff would get in touch with health professionals and to promptly support them to access emergency healthcare if they became ill.
● One relative gave us an example showing how staff had worked with their family member's GP and district nurses, so they would have the care they wanted with their skin health. The relative said, "I am surprised and so is [person's name] at how well [staff] have done in the short time [person's name] has been there."

Staff support: induction, training, skills and experience
● New staff were supported through an induction process. However, we found staff's induction records did not evidence they had completed the full range of induction training. For example, in relation to assessing people's needs, fire safety procedures, accident reporting and falls procedures and health surveillance.
● People and relatives told us staff had the skills to support people. One relative told us, "Staff do understand the best way to help [person's name]."
● Staff had access to a range of training to help them develop the knowledge needed to care for people. The training was linked to the needs of the people they cared for, such as dementia and how to protect people and staff from the spread of infections.
● Further training was planned for staff, including in The Mental Capacity Act, to further promote people's rights.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● We found some people's care assessments were detailed and regularly updated. However, other people's assessments had not been updated as their needs changed. For example, in relation to their mobility needs.
● The care provided did not always reflect standards and guidance. For example, although people's medicinal needs had been assessed, the support provided by staff did not consistently follow National Institute for Health and Care guidance.
● The provider's representative assured us they would review any assessments which required updating.
● People's needs were assessed before they moved to the home. One relative told us, "We looked at [person's name] wider needs and care planning. Nothing was done behind [person's name] back. It was their choice and [person's name] was in the discussions."

Adapting service, design, decoration to meet people's needs
● Some areas of the management of the premises required further development, to reduce risks to people. This included ensuring actions arising from previous fire risk assessments were fully completed and ensuring items which may be harmful to people, such as unsecured furniture and toiletries, were appropriately secured.
● We discussed these concerns with the provider's representative, who took immediate action to address them.
● People's rooms were personalised and reflected what mattered to them.
● The provider had started a programme of premises improvements, to increase the number of rooms with private bathrooms.

Supporting people to eat and drink enough to maintain a balanced diet
● People were positive about their mealtime experiences and we saw people were encouraged to drink enough to remain well. One person told us, "The chef is good, and tells us what is on the menu."
● Relatives gave us examples showing how their family member's preferred food choices were supported, including vegetarian options. One relative said, "[Person's name] is chuffed with the food." Another relative

told us their family member preferred to eat in their own room and said this was respected by staff.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to ensure the registered manager had a good understanding of regulatory requirements, their quality and safety management processes were not always effective and further improvement was required in the staff culture at the home.

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

● The service has a condition of registration with The Care Quality Commission that it must have a registered manager. There had not been a registered manager in post since 31 July 2020. The provider's representative told us the provider was in the process of recruiting a new manager, who would apply to become registered with The Care Quality Commission.
● There had been multiple different managers at the home since our last inspection. Areas we identified at our last inspection requiring improvement had either not been made or had not been sustained.
● The provider's quality and safety auditing systems were not effective, and checks were not regularly done. For example, no provider audits had been done for the period including January 2022 to June 2022.
● Systems to monitor people's medicines had been reintroduced in July 2022. These checks were not effective in ensuring people had the medicines they needed to remain well. For example, in relation to the temperature of storage of people's medicines, and ensuring people received their topical medicines and medicines administered through patches, as prescribed.
● The systems for monitoring areas of people's health did not always work well. This included insufficient oversight to trigger referrals to people's GPs, when people experienced weight loss.
● The provider's audits had not identified or implemented improvements in relation to people's assessments, requirement to update some people's personal emergency evacuation plans, food storage, or premises improvements we identified.

This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

● The provider's representatives understood their responsibility to be open in the event something went wrong with people's care.

At our last inspection the provider had failed to inform us about key events which happened in the home.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● The Care Quality Commission had not been promptly notified of three separate instances where a person living at the home had sustained bruising and on one occasion a cut to their jaw in June 2022 and July 2022.
● The provider had not met their regulatory responsibilities to promptly inform us about significant events that happened at the service. For example, we had not been promptly informed when the supervisory body had authorised Deprivation of Liberty Safeguard (DoLS) for some people who lived at the home.

This was a continued breach of Regulation 18 of the Care Quality Commission Registration Regulations 2009, Notifications of other incidents.

Continuous learning and improving care
● The absence of regular and effective checks meant there was a risk lessons would not be learnt. For example, in relation to people's safety and requirements to notify The Care Quality Commission of significant events in the home.
● Staff gave us examples where learning was recently taken from some provider checks and used to drive through improvements. For example, in relation to controlled drugs recording.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Relatives told us they had been listened to when they had made suggestions for improving the way the home was run.
● Staff told us the recently introduced oversight from the provider's representative had started to make improvements in the care provided. Staff said, after a period when they had not felt supported, support to them was now improving. For example, one staff member told us, "We have staff meetings and [senior staff] do keep us informed. You can also go on your own to [provider's representative's name] if you don't want to say things in front of the team."
● Relatives and staff gave us examples showing how they worked with district nurses and people's GPs to promote people's health.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to reduce potential risks to people in relation to medicines administration and to ensure people's risks were consistently managed.

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 Systems and processes were not operated effectively to prevent abuse of service users.

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 17 HSCA RA Regulations 2014 Good governance Governance systems were not established and operated effectively to drive through improvements in practice in relation to this regulation.

The enforcement action we took:

Warning notice