Wythall Residential Home Limited

Wythall Residential Home

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
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 carried out a previous unannounced inspection of this service on 27 and 28 July 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance. At our last inspection, improvements were required around medicines management, managing people's risks, risks within the environment, quality of record keeping and quality assurance systems.

At the last inspection we recognised that the provider had failed to appoint a registered manager. This was a breach of regulation, and we issued a fixed penalty notice. The provider paid this in full.

At this inspection we found the provider remained in breach of regulation. The service remains rated requires improvement.

Whilst some improvements to record keeping and managing people's risks had been made and a new governance system had been implemented, we continued to find improvements were needed in these areas. Systems and processes to safeguard people from the risk of abuse or avoidable harm needed to be more robust. Staff had not always followed the provider's medicines procedures or national guidance when ordering, administering, or storing medicines. We identified some shortfalls during our inspection.

Feedback we received from people, relatives, and staff we spoke with during the inspection was positive. People told us they felt safe living at Wythall Residential Home.

People and relatives told us the home was managed well and felt confident to raise matters with the managers. The service still did not have a registered manager in post. However a manager had been appointed and was applying to be registered at the time of our inspection.

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.

Rating at last inspection and update
The last rating for this service was requires improvement (published 19 November 2022) and there were

breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. This service has been rated requires improvement for the last 3 consecutive inspections.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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 undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe and well-led.

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 Wythall Residential Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified continued breaches in relation to safe care and treatment, medicines management and good governance.

Please see the action we have told the provider to take at the end of this report.

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?

Requires Improvement

The service was not always safe.

Details are in our safe 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.

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 team consisted of 2 inspectors on the first day and 1 inspector and an Expert by Experience on the second day.

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
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 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A registered manager from one of

the provider's other homes was moving permanently to Wythall Residential Home and had applied to become registered with CQC. We are currently assessing their application.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we held about the service since the last inspection. We sought feedback from the local authority who commission the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 7 people who used the service and 5 people's relatives about their experiences of the care provided. We spoke with a registered manager from one of the provider's other homes who was supporting the service, the area manager, general manager, the nominated individual, 3 care staff and the cook. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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.

We reviewed a range of records. This included 3 people's care plans, medicine administration records (MAR) and 3 staff recruitment files. We viewed a variety of records relating to the management of the service including audit systems.

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's systems and processes were not operated effectively to prevent abuse of service users. This was a continued breach of regulation 13 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 13.

● Systems and processes to safeguard people from the risk of abuse or avoidable harm needed to be more robust.
● During the inspection we reviewed 2 potential incidents of safeguarding concern. However, the concerns were not escalated externally to appropriate agencies for further investigation, or to CQC as required. This meant we could not be assured all actions had been taken to protect people from the risk of abuse or avoidable harm. Following the inspection the provider notified the local authority and submitted statutory notifications to CQC in relation to the incidents.

Improvement was required in the provider's systems and processes to ensure people were kept safe, incidents were appropriately investigated, and lessons were learnt to prevent future occurrences.

Systems had not been established and operated effectively to prevent abuse of service users. This was a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt safe living at Wythall Residential Home. One person told us, "I like living here, it's very pleasant. Staff are all kind. I feel safe here, I don't have to worry about anything".
● Staff received safeguarding training and were able to demonstrate some knowledge of what action they would take if they had any concerns. One staff member told us, "I would report it to the manager, they are very good with feedback here". However, we found not all staff understood their responsibility to immediately escalate safeguarding concerns out of hours. The local safeguarding policy did not provide enough detail to tall staff what to do in these instances.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

At our last inspection the provider had failed to reduce potential risks to people in relation to medicines

administration and to ensure people's risks were consistently managed. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Staff did not always follow the providers procedures or relevant national guidance around medicines management.
● One person had not received 1 of their medicines as prescribed for 7 weeks. There was no documented evidence why this medicine had stopped. Following the inspection, managers told us this medicine had been stopped on advice of the GP however a staff member had not recorded this information in the medicine records in line with NICE guidance [SC1].
● We found prescribed creams and thickener, (a thickening agent used in drinks and food to help people who suffer with swallowing difficulties) in unlocked cupboards in communal areas of the home. This placed people at risk of harm if accidently ingested.
● Stock levels of medicines did not always correspond with the records in place. This meant the manager did not have accurate oversight of what medicines were in the home. Staff did not always record reasons when a medicine had not been given as prescribed. Staff did not always follow processes to monitor patients when giving 'PRN' (medicines given as required rather than at prescribed times) which meant staff could not be assured people were only having these medicines when required clinically.
● Systems were not robust enough to demonstrate food safety was effectively managed. For example, we observed food items that had exceeded their use by date and food items which had not been clearly labelled or stored in airtight containers. Staff who had completed an audit prior to our inspection had not identified these concerns. This increased the risk of service users experiencing ill health.
● Communication between shifts was not always effective. A visiting professional told us recommendations regarding people's care was not always passed on between shifts, however, felt this had started to improve.

Systems were either not in place or robust enough to demonstrate safety was effectively managed, this was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection action was taken to address the issues we identified during our inspection. The provider had communicated with staff regarding the concerns around medication and implemented more checks; the kitchen had been deep cleaned, and new storage and labelling had been put in place with daily checks by senior staff.

On the second day of our inspection the Food Standards Agency was also completing an inspection. As of 6 July 2023, the service was awarded a 5-star rating having demonstrated compliance with food safety and hygiene legislation.

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.

● People were supported to make decisions when they were able to.
● Staff had received training on MCA and DoLS.

Staffing and recruitment
● During our inspection visits we saw there were enough staff to provide safe care and treatment. Staff responded to people's needs in a timely way. However, the manager told us they had vacancies which they were recruiting to. Staff vacancies were covered by existing staff or agency that were block booked for consistency.
● One person who used the service told us, "Sometimes there's enough, sometimes there isn't. I don't go without anything when they are low, it just means they take a bit longer getting to me".
● Relatives we spoke with shared mixed views about staffing levels. One relative told us, "There's loads of staff now since the last inspection. They've made improvements to staffing levels". Another relative said, "There's not enough staff on a weekend, it feels a bit more chaotic. There are usually 2 carers and a senior. The problem is when somebody calls in sick, there can be less".
● Staff were recruited safely. Disclosure and Barring Service (DBS) checks for staff were in place along with appropriate references and proof of identity. 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
● People were not always protected from the risk of infection. We found a bird feeder in a food storage area which was not in line with national guidance on feeding birds during the Avian Flu outbreak. Some food items were not always stored safely.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● 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's infection prevention and control policy was up to date.

Visiting in care homes
● There were no restrictions placed on visiting and visitors could access the home freely.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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; Continuous learning and improving care

At our last inspection we found the provider's governance systems were not established and operated effectively to drive through improvements in practice in relation to this regulation.

Not enough improvement had been made at this inspection and the provider had not met all of the requirements of the warning notice previously issued. The provider was still in breach of regulation 17.

- Systems and processes were not fully embedded to identify and monitor the quality of the service and drive improvements.
- Medicine audits had identified where errors occurred but did not contain sufficient detail to be able to identify the root cause or trends. During the inspection we did not see any evidence of investigations into the ongoing errors. Following the inspection, the provider submitted audits they had completed, along with actions taken. Findings were shared with staff to address issues through staff meetings and supervisions.
- The provider's daily kitchen checks had not identified the issues we found around food storage as detailed in the safe section of this report.
- Systems were not effective in ensuring allegations of abuse or improper treatment were robustly recorded or reported to external agencies as appropriate.
- Accidents and incidents were mostly recorded including actions taken. However, there was no evidence of how these were followed up or analysed to identify any patterns or trends which would help drive improvement to the overall quality of the service.
- Managers reported information governance concerns where certain staff had removed information such as audit results from the service meaning these could not be located or used to evidence work undertaken. Managers told us they had identified which staff had removed or destroyed information and these staff had been removed from the service. An electronic system was in the process of being introduced at the time of the inspection which would reduce the risk of reoccurrence.

Systems and checks had improved since our last visit, but we found some improvements were still needed. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

● Despite our findings above, we found some improvements had been made since our last inspection. The provider had introduced a schedule of audits to monitor the performance of the home which was accompanied by an action plan giving named staff responsibility for specific tasks. In response to missing paper-based information; and audits not always being effective to drive improvement, as above, managers had procured a new electronic system to support with training, communication, audits, policies, and procedures to support with overall governance.
● Following the last inspection, the provider was issued with a fixed penalty notice for failing to have a registered manager in post. The service remained without a registered manager; however, management support was being provided internally by experienced managers. The provider's representative told us one of the managers would be staying permanently and had applied to register with the Care Quality Commission.
● The provider had met the legal requirements to display the services latest CQC ratings in the home and on their website.
● Staff were kept updated with relevant information through regular meetings and supervisions where they received some feedback about their performance.
● A relative told us they had been notified of an incident involving their family member and the action the manager had taken.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People spoke positively about staff and the support they received from them. A person told us. "The staff help you all they can, all the staff are very good".
● A staff member told us, "Management has been up and down, and we have [managers name] here full time now which is lovely. All of us are so pleased they are going to be here permanently".

Engaging and involving people using the service and staff fully considering their equality characteristics; Working in partnership with others
● The manager gathered people's feedback by completing monthly audits. During a recent audit, people had identified there was no religious events taking place, this was identified as an action to address, although we did not see an action plan for this at the time of our inspection.
● A relative told us, "We don't have anything like meetings which involve us in the running of the home. However, if I wanted to ask anything I feel I am able to".
● The provider held staff meetings where they discussed areas of learning. For example, a recent meeting talked about findings from the inspection and managers audits and how they would be implementing a checklist to address concerns.
●Staff worked in partnership with others such as external healthcare professionals to ensure people received healthcare when they needed it.
● A visiting healthcare professional told us they had noticed recent improvements over the last 2 months and reported the new manager was visible and approachable.

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 failed to ensure people were provided with safe care and treatment.

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 ensure safeguarding referrals were made and people were protected from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to assess, monitor and improve the quality and safety of the service provided.