Review of compliance

Wythall Residential Home Limited Wythall Residential Home	
Region:	West Midlands
Location address:	241 Station Road Wythall Birmingham West Midlands B47 6ET
Type of service:	Care home service without nursing
Date of Publication:	April 2012
Overview of the service:	Wythall residential home provides accommodation with personal care for up to twenty two people. It does not provide nursing care.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Wythall Residential Home was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 13 - Staffing

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 1 March 2012, observed how people were being cared for, looked at records of people who use services and talked to people who use services.

What people told us

Worcestershire County Council social services told us in late January 2012 that they had concerns about the way that the provider had managed risk for one person who used the service. This had led to actual harm from a fall.

We visited the service on 1 March 2012. The acting manager told us that there were 21 people living in the home at that time. We followed the care of three people. We met and spoke with two of those people.
One person had a low level of need for support and care. We asked for their view on the home. They told us "it's as good as it can get. Everyone is kind here."

We looked at people's care records and found that the quality of assessment of need, care plans and review of care plans varied. People with complex conditions did not always have risks to their health and well being consistently managed and this put them at risk. We have required the provider company to comply with regulation and improve this.

We spent two hours in the communal rooms of the home. We saw that workers and managers treated everyone with patience, kindness and respect. There were three care workers on duty and they were stretched over lunch time to provide the level of individual attention that some people needed. We have asked the provider company to improve this. We spoke to another person over lunch. They told us that they felt happy, safe and settled at the home. They said that there were no over restrictive rules and that workers were very

attentive.
We looked at the bedrooms of two of the people whose care we followed. We saw that they were clean, warm and comfortable.

We spoke to care workers on duty. They were able to tell us about people's needs and care plans. They spoke very positively about the dementia awareness project that the staff team was involved in with Worcestershire County Council. Workers understood their responsibilities to safeguard people from risk of abuse.

Workers and managers held qualifications in social care. The provider company was not able to show us accurate records of up to date staff training in compulsory subjects such as safe moving and handling of people and food hygiene and infection control. We have asked the provider to improve planning for keeping skills and knowledge regularly updated.

The manager is not registered with us.

What we found about the standards we reviewed and how well Wythall Residential Home was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People who use the service do not always experience effective and safe care and support that meets their needs and protects their rights. Risks are identified for people with complex conditions but not consistently managed.

Outcome 07: People should be protected from abuse and staff should respect their human rights

People who use the service are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

People's health and welfare needs are generally met by sufficient numbers of appropriate staff. The service would improve by staffing levels being kept under review against the specific needs of people especially at meal times. Also staff training needs should be planned for.

Outcome 15: The service must tell us about what kinds of services it provides

People who use the service benefit from the knowledge that the Care Quality Commission is informed of the services being provided.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the

improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
Worcestershire County Council social services told us in late January 2012 that they had concerns about the way that the provider had managed risk for one person who used the service. This had led to actual harm from a fall.

We visited the service on 1 March 2012. The acting manager told us that there were 21 people living in the home at that time. We followed the care of three people. We met and spoke with two of those people.

We looked at their care files and saw that each person had a written assessment of their needs. These assessments were made before the person was admitted to the home.
Two people had complex conditions including confusion. One person also needed assistance with mobility and this was made clear on their pre admission assessment. We saw that there was no risk assessment or management plan for their mobility. There was a falls risks assessment that concluded the person was likely to fall. Although the pre admission assessment identified that the person walked with the assistance of a stick and a frame, they were admitted to the home without their frame. Accident records showed that within a a few days of admission the person fell and sustained an injury.

The file of the other person with complex conditions contained a lot of information about them including their health, background, hobbies and likes and dislikes.
We saw from an assessment undertaken by the provider that the person was at high

risk from inadequate nutrition. There was a written management plan for this that was to be checked monthly. We saw that the plan, including checking weight had not been updated in February 2012. We asked the manager about this. She told us that the person was staying longer than anticipated but agreed that reviews and updates should have been done as planned for someone with such complex conditions.

She told us that the person's weight could not be measured again until the sit down weighing scales arrived. The provider shared the use of this equipment between a number of homes.
We spoke to kitchen staff about the records of the person's food and drink intake. We saw that there were records made each day but they were inadequate and incomplete. Workers were relying on memory and approximation at the verbal handover of shifts to gauge the amount of food and drink taken and therefore the level of risk to the person's health.
Care records showed that this person had suffered a fall after admission to the home. Their falls risks assessment had not been reviewed after this event. We spoke with the person. We saw that they were independently mobile and active but became highly confused in the presence of a stranger.

We saw that the third person whose care we followed had a comprehensive set of up to date records including medical history and risk assessment and management plans. They had a detailed care plan and general and specialist health care records. We spoke with them. They told us that they had been at the home just a few months. They said that although they missed their own home they were happy at the service. They said, "it's as good as it can get. Everyone is kind here." We saw that their social worker visited while we were there to check that their placement at the home was working well. We heard the social worker tell the manager that it was.

We spent two hours in the communal rooms of the home. We saw that workers and managers treated people with patience, kindness and respect. This included a person who was very confused and constantly active. We spoke to another person over lunch. They told us that they felt happy, safe and settled at the home. They said that there were no over restrictive rules and that staff were very attentive. We asked them if they thought that there were enough workers on duty. They told us that they thought there were.

We looked at the bedrooms of two of the people whose care we followed. We saw that they were clean, warm and comfortable.

We spoke to the senior care worker on duty in charge of the shift. She knew people's care needs. She told us that she held the NVQ in health and social care at level two and at level three. The senior care worker described a new training project that staff in the home, including managers were engaged in at that time over five months. She said it was about making the whole service an enabling one for people with dementia. We spoke to another care worker on the afternoon shift. She too spoke about the dementia care training project very enthusiastically. She said that she was confident that it would help the service to make a big difference to people with confusion.

Other evidence
On 30 January 2012 Worcestershire County Council social services sent us their report on an investigation into injury that had happened to a person whose used the service.

They concluded that some poor practice by the service had contributed to this incident. The provider had obtained insufficient information about the person's medical history, no proper care plan was in place and there had been inadequate assessment of the risks that the person's conditions posed to them.

Our judgement
People who use the service do not always experience effective and safe care and support that meets their needs and protects their rights. Risks are identified for people with complex conditions but not consistently managed.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We visited the service on 1 March 2012. We spent two hours in the communal rooms observing the way that people were looked after. We saw that managers and care workers treated people with respect and with patience and warmth. This included people who had a high level of need and attention because of dementia, confusion and agitation.

We saw the provider's staff training matrix for the service. This showed that over half of the staff team had training in safeguarding adults from the risk of abuse. See also our comments under outcome thirteen staffing about planning training for the team.

We spoke to two care workers. Both were clear about their responsibilities within their role for safeguarding vulnerable people. Both workers also spoke positively about the dementia awareness project that the whole staff team was involved with at different levels over five months. They were confident that this training would improve the experiences of people with dementia who used the service.

Other evidence

Our judgement
People who use the service are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are minor concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We visited the service on 1 March 2012. The manager told us that there were twenty one people living there at the time. We saw that there were three care workers including a senior on shift during the morning. This team was replaced at 2pm by three other workers and a different senior. The manager was on duty through the day. A cook was on duty and the main meal was served at 12pm. The manager told us that a designated care assistant managed the evening meal that had been prepared by the cook. The manager told us that this was the regular staffing level for the home. There were also two care workers awake on duty each night.

We asked a person who used the service whether they thought there were sufficient staff on duty at the home. They told us they thought that there were. We asked if people had to wait if they needed assistance to the toilet and they said not. We spent two hours in the communal rooms of the home. We saw that care workers were fully occupied all of that time helping people to the toilet and then serving meals and helping people to eat. Most people were in the communal rooms during the day but some people stayed in their bedrooms. Some people had to be fully assisted to eat their meal. One person had a relative with them to do this.
One person was very active and we saw them walking around the home constantly. We saw that workers were alert to their whereabouts. This did put pressure on the team when another person required the help of two workers to assist them in the toilet.
We asked the workers that we spoke to whether they thought that staffing levels were sufficient to look after the people that used the service at that time. They told us that in general they were but that they were a bit stretched over meal times. They said that the

manager was usually available to help out if necessary.
We have asked the provider company to keep under review staffing level at the service at meal times.

We saw that workers were well groomed and wore white tunics that made them easily identifiable to people who used the service. Workers were polite, friendly and warm with people and talked to them while they assisted them. The manager told us that the whole staff team were involved with Worcestershire County Council project on dementia care awareness. Workers that we spoke to were positive about this.

The manager told us that senior care assistants in charge of shifts held NVQ's in health and social care. The provider's staff training matrix showed that ten out of thirteen workers at the service held an NVQ in health and social care at level two. It showed that five workers also held the qualification at level three. The manager and deputy held a level four qualification and the registered manager's award.

The manager is not registered with us.

The matrix also showed that only two workers had recent training in safe moving and handling of people. Only one worker had an up to date food hygiene certificate although care workers prepare supper for people. Only one worker had recent training in infection control.
The manager wrote to us on 21 March 2012 and told us that the training matrix was not accurate. She told us that the provider company was working on getting more accurate data about staff training especially for the mandatory subjects such as moving and handling which, should be updated regularly.

We have asked the provider company to improve the planning of staff training to make sure that mandatory skills are up dated and skills and knowledge required to meet specific needs of people who use the service are identified.

Other evidence

Our judgement
People's health and welfare needs are generally met by sufficient numbers of appropriate staff. The service would improve by staffing levels being kept under review against the specific needs of people especially at meal times. Also staff training needs should be planned for.

Outcome 15:
Statement of purpose

What the outcome says

This is what people who use services should expect.

People who use services:
* Will benefit from the knowledge that the Care Quality Commission is informed of services being provided.

What we found

Our judgement

The provider is compliant with Outcome 15: Statement of purpose

Our findings

What people who use the service experienced and told us
On 23 March 2012 the provider company sent us a copy of the statement of purpose for the service.
The statement of purpose was updated in 2011.

Other evidence

Our judgement
People who use the service benefit from the knowledge that the Care Quality Commission is informed of the services being provided.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	Why we have concerns: People's health and welfare needs are generally met by sufficient numbers of appropriate staff. The service would improve by staffing levels being kept under review against the specific needs of people especially at meal times. Also staff training needs should be planned for.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People who use the service do not always experience effective and safe care and support that meets their needs and protects their rights. Risks are identified for people with complex conditions but not consistently managed.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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