Watford House Residential Home Ltd

Watford House Residential Home

Inspection report

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Date of inspection visit:
01 March 2022

Date of publication:
24 March 2022

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
Watford House Residential Home is a care home providing support with personal care needs and accommodation for up to 43 people, aged 49 and over, in one adapted building. At the time of this inspection, 39 people were living there, some of whom were living with dementia.

People's experience of using this service and what we found
People were not always safe as the physical environment was not safely maintained. Substances hazardous to health were left in communal areas and some staff practice did not adhere to best infection prevention and control guidance.

The provider could not evidence people received their medicines as prescribed.

The provider did not have effective quality monitoring procedures in place to drive good care.

Staff understood how to safeguard people from the risk of abuse and knew what to do if they suspected something was wrong.

People had assessments of risk associated with their care and support.

The provider had kept us informed about key events and had good working relationships with others involved in peoples care. People and staff told us they found the management team to be approachable.

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

Rating at last inspection
The last rating for this service was good (published 12 July 2021).

Why we inspected
We received concerns in relation to people's safety. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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. This included checking the provider was meeting COVID-19 vaccination requirements.

Following our inspection site visit the provider took action to mitigate the immediate risks to people including fire safety improvements and removal of items likely to cause harm.

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 keeping people safe and the providers monitoring of the provision of care at this inspection.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Watford House 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 Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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
This inspection was completed one inspector.

Service and service type
Watford House Residential Home 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.

The service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and Healthwatch. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection
We spoke with four people who used the service about their experience of the care provided and two relatives. We spent time in the communal area observing the support people received. We spoke with five staff members including one carer, one senior carer, maintenance person, deputy manager and registered manager. We also spoke with one visiting social care professional. We looked at two peoples care and support plans, multiple medicines records and several documents relating to the monitoring of the location and health and safety checks. We checked the recruitment of two staff members.

After the inspection
We continued to seek clarification from the provider to validate evidence found and to confirm the action they had taken to mitigate risks to people.

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 good. At this inspection the rating has changed to 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.

Assessing risk, safety monitoring and management

● The provider failed to ensure their fire safety systems were effective. We found several fire exits had been blocked by items such as shelving, hoist and other equipment. We saw several locations throughout the building did not have effective fire safety signage in place to direct people in an emergency. These issues put people at risk of harm in the event of fire.

●The provider did not consistently ensure the physical environment was safe for people. For example, we saw radiators and pipe work which had not been covered and were hot to the touch. This placed people at the risk of burns should they have contact with the exposed metal work. Some windows did not have any window restrictors in place, and some had restrictors which were not secured using tamper proof fixtures. This put people at the risk of harm as a result of a fall from height.

● We saw dishwasher cleaning tablets were stored in cupboards accessible to people living with dementia. We saw individually prescribed drinks thickeners' were left in communal cupboards. In other areas we saw cleaning products, prescribed creams and individual toiletries had been left in communal areas. These issues put people at the risk of harm from accidental ingestion.

● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. We saw a cupboard in a communal bathroom where individual shaving equipment and a toothbrush was placed in contact with a used hairbrush and with an unidentified substance. In other areas we saw light pull switches which were stained, indicating ingrained dirt. These issues put people at risk of harm from communicable illnesses.

● Staff members did not record peoples prescribed topical creams. One person's creams had not been recorded since August 2021. The other five records we looked at did not have any recording to indicate people had received their creams as prescribed. We saw one person's nutritional supplements had not been recorded on two occasions in the last month. The provider did not have a system in place to record where on the body pain patches were applied to ensure skin had enough time to recover between applications. These issues put people at the risk of not receiving their medicines as prescribed to maintain good health.

Following this inspection site visit, we received evidence from the provider confirming they had acted to remove the immediate risks to people. Including, but not limited to, removing all obstructions from fire exits, limiting access to hot metal work, the safe storage of drinks thickener and the introduction of checks to ensure medicines are administered as prescribed.

We found no evidence that people had been harmed however, systems were either not in place or robust

enough to demonstrate safety was effectively managed. This placed people at risk of harm. These issues constitute a breach of Regulation 12: Safe Care and Treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt safe living at Watford House Residential Home. One person told us they felt safe and their worries had been removed by moving in there. People were supported to identify and mitigate risks associated with their care and support. Staff members knew people's individual health needs and how to support them in accordance with their wishes.
● Assessments of risks associated with people's care had been completed. These included, but were not limited to, risks related to mobility, skin integrity and weight loss.

Using medicines safely
● Despite our findings regarding the effective recording of medicines, staff members had received training in the safe administration of medicines. In addition, they were regularly assessed as competent to ensure they were safe to support people. However, although the provider completed monthly checks of medicines they failed to identify or rectify the recording errors we found. Staff members responsible for recording medicines had not highlighted issues to colleagues or the management team.
● Some people took medicines only when they needed them, such as pain relief. There was appropriate information available to staff on the administration of this medicine, including the time between doses and the maximum to be taken in a 24-hour period.

Preventing and controlling infection. How well are people protected by the prevention and control of infection?
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● 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 accessing testing for people using the service and staff.
● 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
● The provider was supporting visits in line with the Governments guidance.
From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency.

● The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Staffing and recruitment
● The provider did not consistently follow safe recruitment processes when employing new staff members. For example, they failed to ensure staff members had the right to work in the UK. However, they did check references with previous employers, and they did checks with the Disclosure and Barring Service (DBS). The DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● The provider told us they had measures in place to mitigate the risks associated with COVID-19 related staff pressures.
● The provider had systems in place to address any unsafe staff behaviour including disciplinary processes and re-training if needed.
● People were supported by enough staff who were available to safely and promptly assist them. Those we spoke with told us they were helped when they needed it and there were no delays in the support delivered. One relative said, "We are always assured there is someone around to help if needed."

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse and ill treatment as staff members had received training on how to recognise and respond to concerns. We saw information was available to people, staff and visitors on how to report any concerns.
● The provider had systems in place to make appropriate notifications to the local authority to keep people safe. We saw the provider acted on recommendations from health and social care partners where needed.

Learning lessons when things go wrong
● The provider looked at incidents which affected the safety of people. For example, the provider reviewed incidents and accidents to ensure appropriate action was completed.

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 the last inspection this key question was rated as requires improvement. At this inspection 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had ineffective systems to monitor the quality of the service they provided. For example, their checks had failed to identify or rectify exposed hot pipes and radiators. They failed to identify unsecured cleaning products were a potential risk to people and failed to safely store them.
- They failed to identify or correct the blocked fire escape routes or the lack of fire signage.
- Despite having regular medication quality checks in place, they had failed to identify staff members were not recording if prescribed medicated creams had been administered as directed.
- Despite doing regular health and safety checks of people's physical environment they failed to identify some window openings were not restricted and others had incorrect fixings.

Following this inspection site visit we received evidence from the provider confirming they had acted to remove the immediate risks to people. Including, but not limited to, removing all obstructions from fire exits, limiting access to hot metal work, the safe storage of drinks thickener and the introduction of checks to ensure medicines are administered as prescribed.

We found no evidence that people had been harmed however, managerial oversite and environmental assessments were either not in place or robust enough to demonstrate their quality monitoring was effective. These issues constitute a breach of Regulation 17: Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A registered manager was in post and was present throughout this inspection. The registered manager and provider had appropriately submitted notifications to the Care Quality Commission. The provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale.
- We saw the last rated inspection was displayed in accordance with the law at Watford House Residential Home.

Continuous learning and improving care

- The management team told us they kept themselves up to date with developments and best practice in health and social care to ensure people received positive outcomes. This included regular interactions with

health care professionals and updates from social care partnership agencies.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People told us they felt involved in decisions about where they lived including what to do and what to eat. The provider had systems in place to receive feedback from people and relatives. One person said, "I love it here. They (staff) can't do enough for you and we can always have our say."

● All those we spoke with said the management team was approachable and they felt supported by them. Staff members told us they found the management team supportive and could go to them at any time. The provider completed regular resident meetings where they welcomed people's feedback on the care they provided. One person told us they were informed about the developments the provider was making with the building next door which they found very interesting. They went on to say how much they liked the updates on the development.

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.

● The provider was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation which all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment.

Working in partnership with others

● The management team had established and maintained links with the local communities within which people lived. For example, GP practices, district nurses and social work teams.

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 did not ensure the physical environment was safe for people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to identify and correct issues with the provision of care and accommodation.