Wychbury Care Services Limited

Wychbury Care Home

Inspection report

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Date of inspection visit:
18 December 2019

Date of publication:
04 February 2020

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Wychbury Care Home is a residential care home providing personal care to 39 people aged 65 and over at the time of the inspection. The service can support up to 42 people.

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

Risks to people's safety had been assessed and action was taken to reduce risks where possible. People were kept safe by staff who knew how to identify and report any concerns of abuse. There were sufficient numbers of staff to support people and medicines were managed in a safe way.

People and staff felt the service was well led. There were systems in place to monitor quality and people were given opportunity to feedback on the quality of the service. The provider was open and transparent where things had gone wrong and had been proactive in making improvements where needed.

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

Rating at last inspection (and update)
The last rating for this service was good (published 01 August 2019).

Why we inspected

The inspection was prompted in part by notification of a specific incident. Following which a person using the service died.

The information CQC received about the incident indicated concerns about the management of falls from height. This inspection examined those risks.

We found no evidence during this inspection that people were at risk of harm from this concern. Please see the Safe and Well Led sections of this full report. We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

Follow up
We will continue to monitor information we receive about the service until we 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?

Good

The service was safe.
Details are in our safe findings below.

Is the service well-led?

Good

The service was well led.
Details are in our well-Led findings below.

Wychbury Care 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.

Inspection team
The inspection was completed by an Inspector and an Assistant Inspector.

Service and service type
Wychbury Care 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 that 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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection-

We spoke with two people who used the service and four relatives about their experience of the care provided. We spoke with three members of staff as well as the provider and the registered manager.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Good

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Assessing risk, safety monitoring and management

● Prior to the inspection, we received notification from the provider of an incident where a person had fallen and sustained significant injuries. The information provided raised concern about the safety of the environment. At this inspection, we found that the provider had taken appropriate action to assess and act on any identified risks relating to the environment. For example, the provider had sourced additional equipment to minimise risk to people in future. The registered manager and provider had been proactive in addressing the risk to others once this had been identified.

● Other risks to the health and well being of people had been assessed. Risk assessments were in place and staff understood their role in reducing risks where possible. For example, where people may experience distress, care records identified possible triggers to the distress and how staff should respond to these to ensure the person's safety. Staff knowledge reflected the information held in care records.

● Although staff displayed an in depth knowledge of people and the risks to their safety, we identified some care records that required more detail to reflect staff knowledge of people. The registered manager contacted us after the inspection to inform us that these additions were being made to records.

Systems and processes to safeguard people from the risk of abuse

● People and their relatives told us they felt safe. One relative told us, "They [staff] are ultra safety conscious."

● Staff understood their responsibilities in relation to safeguarding people from abuse and could confidently detail the action they would take if they identified concerns. One member of staff told us, "I would report it [my concern] to the [registered manager] immediately. I would take it to the provider and if I wasn't happy, take it further."

● Although no concerns had been raised since the last inspection, the registered manager understood the action they should take to safeguard people should an incident occur.

Staffing and recruitment

● People told us there were enough staff to meet their needs. One person said, "I had a fall and staff were marvellous, I wouldn't be frightened as it's a wonderful service and staff did come quickly."

● We saw that there were sufficient numbers of staff to support people. Staff were visible in communal areas and people were supported in a timely way where needed.

Using medicines safely

● People and their relatives felt they were supported with their medicines in a safe way. One relative told us, "They [staff] explain what they do, [person] is getting the correct medication."

● Records we looked at indicated that people received their medicines as prescribed. Records had been completed accurately, and medicines were stored safely.

Preventing and controlling infection

● There were safe systems in place to prevent and control infection. Staff had access too and were seen to wear personal protective equipment such as gloves and aprons where needed. The home was clean, tidy and free from odour.

Learning lessons when things go wrong

● The registered manager displayed a commitment to learning where things go wrong. Any accidents and incidents that occurred, were recorded and reviewed to ensure any learning could take place to reduce risks to people in future. For example, where people had fallen, equipment was put into place to reduce risks in future and referrals to external professionals such as the falls team, were made.

Good

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 good. At this inspection this key question has remained the same. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

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

● People and their relatives spoke positively about the registered manager and told us the service was well led. Comments made included, "If I ever have to speak to her [registered manager], she is always available" and, "As soon as we came here, we could tell it was a caring home and we have not regretted the move. This is [person's] home." The registered manager had a visible presence around the home and was seen to spend time with people. People were visibly familiar with her and comfortable in her company.

● Staff told us they were supported by the management team and that the service was well led. One staff member told us, "The management are lovely, the staff are lovely, and the people are just amazing. We laugh everyday."

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 registered manager and provider had acted on their duty of candour. We were made aware prior to the inspection of an incident where a person experienced significant injuries. The provider had been open and transparent about this and shared information with all relevant agencies to ensure this investigated appropriately.

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

● There were systems in place to monitor quality. This included reviews of people's care, medication checks and audits on infection control. Where areas for improvement were identified, these were acted upon. Some of the audits seen had not been completed recently. We raised this with the registered manager who informed us that this was due to their planned monitoring systems and not an error, and that they had a schedule they followed to ensure all areas of care provision would be monitored. Following the inspection, the registered manager sent us their monitoring planning tool that laid out their plans for monitoring the quality of the service in both 2019 and 2020.

● The provider and registered manager understood and met the regulatory requirements of their role. Notifications of incidents had been reported to us as required and the most recent inspection rating had been displayed within the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were given opportunity to feedback on the quality of the service via questionnaires. These were sent out annually. Where people made recommendations for improvements, these were acted upon. No surveys had been sent out since our last inspection in July 2019.
● People and staff told us they were engaged in the service and felt able to approach the management team with feedback as and when needed. One person told us, "[Registered manager] is just excellent. There were minor issues in the beginning and she was very respectful."

Continuous learning and improving care / Working in partnership with others
● Both the registered manager and provider displayed a commitment to improving care and working with others to achieve this. Records showed that the registered manager had worked with other professionals including the falls team, occupational therapy and community nurses to improve health outcomes for people and ensure their safety.
● The registered manager displayed a passion for learning from incidents to improve care quality for others. For example, following an incident in which a person fell in a communal area, the provider had been proactive in seeking advice from other professionals and obtained additional equipment to ensure people's safety in future.