The Leaders Of Worship And Preachers Homes

# Westerley Residential Care Home for the Elderly - Woodhall Spa

## Inspection report

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## 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
Westerley Residential Care Home for the Elderly is a residential care home providing accommodation and personal care to up to 30 people in one adapted building. The service provides support to older people. At the time of our inspection there were 28 people using the service.

People's experience of using this service and what we found
The risks to people's safety were not always fully identified and some assessment tools used were not regularly updated to ensure people's current needs were reflected. Assessed measures to support people were not always in place and some environmental risks to people's safety had not been robustly assessed.

Medicines were not always well managed, and some aspects of infection prevention and control did not reduce the risks of the spread of infection at the service. This included staff not wearing masks on the first day of our inspection

People did not always receive care from enough appropriately trained staff. There was a lack of adequately deployed ancillary staff to support care staff and allow them to manage people's care needs in a timely way.

People's nutritional needs were not always well managed.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Quality monitoring processes were either not in place or had not highlighted the concerns we found at our inspection. People, relatives and staff did not always feel engaged and listened to.

There were safe staff recruitment processes in place.

Where any safeguarding concerns had been raised to the registered manager, they had worked with the local safeguarding team to investigate the concerns and act on the outcome of investigations. The provider worked in line with the duty of candour regulation.

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 (8 February 2019).

Why we inspected
We received concerns in relation to staffing levels and people's care and treatment. As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well-led only.

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

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.
The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well- Led sections of this full report.

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 Westerley Residential Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 safe care and treatment, staffing levels and training, safeguarding people's rights and governance of the service.

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.

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 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.

# Westerley Residential Care Home for the Elderly - Woodhall Spa

**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 carried out by two inspectors and an Expert by Experience. 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
Westerley Residential Care 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. Westerley Residential Care 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 a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before 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. 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 five people who used the service and nine relatives. We spoke with 15 staff members. This included two housekeepers, one cook, nine members of care staff, the deputy manager, the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed five people's care records and a selection of medicines records. We also reviewed several records related to the running of the service such as the training matrix and quality monitoring records.

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.

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; Learning lessons when things go wrong

- The risks to people's safety were not always fully identified and some assessment tools used were not regularly updated to ensure people's current needs were reflected.
- Some people's nutritional needs were not fully assessed. For example, one person had a diagnosis of dysphagia (difficulty in swallowing). Their care plan stated the person was "risk fed". Risk fed refers to the decision a person has made to continue eating and drinking despite the associated risks from having dysphagia. There was no documentation to show the person had made the decision to be "risk fed" or that the risks to the service user had been clearly outlined. There had been no advice sought from speech and language therapy (SALT) team to ensure the person's current diet was suitable for their needs.
- A further person had been assessed as being able to self-administer their own insulin. Information in the person's care plan noted the insulin and administration equipment should be kept in the locked clinical room when not being used. However, we found the person kept the insulin equipment in their room. The person's room was not locked when the person was not in it. This posed a risk that service users who walked with purpose could enter the room and have access to the administration equipment.
- One person living with dementia was entering other people's bedrooms. A sensor mat had been put in place to one side of the person's doorway to alert staff should the person attempt to enter their neighbour's room. However, positioning of the sensor mat meant there was still an opportunity for the person to go undetected into other people's rooms. There had been no risk assessment undertaken to establish if the measures in place were the most effective and least restrictive way of meeting the person's needs.
- One person who had been assessed as requiring a sensor mat by their bed, as they were unsteady when mobilising around their room, had their sensor mat removed from their bedroom. It had been placed between their bedroom and their neighbour's bedroom. This meant staff would not be alerted if the person fell in their bedroom
- Environmental risks were not robustly assessed to ensure the safety of people living at the service. There were three staircases at the service that could be accessed by people. One person living at the service lacked the capacity to understand the risks of using of using these staircases unaided and a member of staff told us the person was at times unsteady when walking. The lack of measures in place to manage this risk put people at risk of avoidable harm.
- There was a lack of clear processes to support staff to learn from events. For example, there was a lack of clear analysis of falls to work to prevent reoccurrence.

Using medicines safely

- People's medicines were not always safely or properly managed. On the first day of our inspection the staff member administering medicines did not finish the morning medicines round until 12 noon. They told us this was due to being interrupted throughout the morning to support other staff. They had, however,

ensured people who required timed medicines received these at the correct times by keeping an alarm on their phone to remind them.

● There were unexplained gaps in people's medicines administration records (MAR) from the previous month where medicines had either not been administered or not signed for. The registered manager told us they had identified issues with gaps in people's MAR when they had given medicines themself recently and were working with staff to address this.

● Some checks to ensure medicines were kept at the correct temperatures had not been carried out. For example, the medicines fridge temperature had only been checked on three days in August up to the first day of our visit. Room temperatures had been completed daily between 6th and 12th August, but then not until 20th August. This put people at risk of receiving medicines which had not been stored correctly.

Preventing and controlling infection

● On the first day of our inspection staff were not wearing face masks as per government guidance. Staff told us this was due to the excessively hot weather making staff more prone to heat stroke. The risk assessment in place did not clearly identify the risks to service users due to staff not wearing masks. It did note staff should wear masks when in close contact with service users. However, we saw staff serving breakfasts to service users and not wearing masks during this task. This lack of robust assessment of risk put service users at higher risk of being infected with COVID-19.

● There were shortfalls in infection prevention and control arrangements. The clinical room was also being used as a staff office. Staff could not wash their hands there between clinical activities. In addition, we observed staff administering medicines from the medicines trolley in this room not following good hand hygiene practices during the process. The lack of accessible hand washing facilities in this room and staff practice increased the risk of infection spreading.

The provider had failed to manage risks relating to people's health, safety and welfare. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staffing levels did not always meet the needs of people using the service. Staff were not always supported by adequate numbers of ancillary staff. There were no housekeeping staff on duty after 2pm on weekdays or at any time during the weekends. The lack of staff working in the kitchen to support with preparing and serving the evening meal meant care staff, as well as providing care, were required to serve the evening meal, manage any laundry and do ad hoc cleaning from 2pm. This increased the risk of service users' needs not being met.

● People's feedback was that the lack of staff impacted on their ability to provide effective care. People told us staff didn't always answer call bells or respond to needs very quickly. This included not supporting people when they asked for care, such as the times they wanted to get up, or receive personal care. One person told us there were times they had needed to wait almost two hours for staff to respond to their call bell. The person told us it was happening more now than when they first came to the service. A further person said, "Yesterday I rang for [personal care] at 1.20pm they (staff) said they couldn't do it then, had to do handover, and have so much to do. It was 2.40.pm before they came. I regularly have to wait."

● The feedback from relatives on the staffing levels were mixed. Some relatives did not think there was any impact of the care their relative received, but others told us either they felt, or their family member had told them, there was a shortage of staff. A relative told us their family member had waited an hour and 40 minutes to be supported to the toilet and were left until 2.30am to be supported to bed one evening. A further relative said, "At one stage they were struggling to get [family member] to bed and had to alter the timings, my relative said they were struggling, there were not many staff on."

This lack of adequate deployment of ancillary staff impacted on the workload of care staff and their ability to provide adequate care for people and is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- Majority of people we spoke with felt safe at the service. One person had felt concerned over another resident entering their bedroom uninvited. However, staff had worked to address this.
- Staff we spoke with showed good knowledge of how to protect people from the risks of abuse and what processes were in place for them to use to report any concerns they had. However, one new member of staff was not clear on their responsibilities on protecting people. They told us they had not received training. We spoke to the registered manager who told us the person had received training, but they would discuss further support for the member of staff to increase their knowledge.
- Where any safeguarding concerns had been raised to the registered manager, they had worked with the local safeguarding team to investigate the concerns and act on the outcome of investigations.

Staff recruitment

- Safe staff recruitment processes were in place. The provider used the Disclosure and Barring Service (DBS) to support safe recruitment. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Visiting in care homes

- The service facilitated visits in line with government guidelines.
- Relatives told us the service facilitated visiting.

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 Good. At this inspection the rating has changed to Requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- People were not always supported by staff who had received appropriate training. Staff training information provided showed not all staff had received appropriate up to date training for their roles. The training matrix showed some staff had not received up to date safeguarding adults training, safety in catering /food hygiene training, nutrition and hydration training, hand hygiene training and COVID 19 training. This lack of training in these essential areas of care meant staff may not always have the most up to date knowledge and skills to provide safe care. The registered manager told us they would address this.
- One person told us they felt staff did not always have an understanding of their health condition and how it impacted on their ability to do things. We saw only five members of staff had completed training to support their knowledge of the person's health condition.
- Staff told us they had not received regular supervisions to support them in their roles. We raised this with the new deputy manager who told us they were working to address this and had a plan in place to ensure all staff were supported with regular supervision.

The lack of adequate training for staff was a further breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet;

- The feedback from people on their meals was mixed. Some people felt their food was not always warm by the time they received it. However, other people were happy with their meals and choices provided. One person told us the staff managed their special dietary needs well.
- Staff told us they did not always have time to provide people with hot drinks mid-morning and in the evenings, as the lack of staff and other duties impacted on their ability to provide this aspect of care for people. This meant people may not always be supported with their hydration needs.
- People had not been weighed on a regular basis; the monthly weight sheets showed people had last been weighed in November 2021. One person's Malnutrition Universal Score Tool, (a nationally recognised tool used to monitor weights) (MUST) chart last reviewed in November 2021, showed their score should have triggered several actions. One of which was to weigh the person weekly. This had not been carried out. Staff's failure to follow this action and the lack of ongoing assessment of the person's needs put them at risk of not receiving safe care.

The lack of management of people's nutritional needs was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

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.

● The provider was not working in line with the principles of the MCA. There was a lack of mental capacity assessments in place for people who lacked capacity. A person who lived with dementia was walking with purpose into other people's rooms. The staff had placed a sensor mat outside their bedroom door to monitor the person's movement. There was no evidence of mental capacity assessments or best interest meetings to support specific decisions being made about the use of a sensor mat to restrict the person's movements.
● Where required applications for DoLS for individuals had not been made. For example, one person who lived at the service had attempted to leave the service unsupervised. The registered manager told us the person lacked the capacity to understand the risks of leaving the service without support. Although the registered manager was assessing if the service could meet the person's needs, they had not considered applying for an urgent DoLS to support the decision to prevent the person from leaving the service alone.

This was a breach of Regulation 13 (4) (b) (d) of the Health Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessment tools used to assess people's needs were not always robust. A Waterlow scoring tool (used to support staff assess people's risk of skin breakdown), we viewed did not reflect the person's needs as some aspects of this nationally recognised tool were not part of the assessment criteria. The person had a neurological condition and the neurological deficit score was not on the Waterlow assessment tool being used. This meant the person's needs were robustly assessed and this could impact on the level of care they received.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were not always referred to relevant external health professional to support their needs. As mentioned in the key question safe, advice and support had not been sought from the SALT team to ensure people's dietary needs were safely managed.
● People told us when they required a doctor the staff supported them to access their GP. Records we viewed supported this.

Adapting service, design, decoration to meet people's needs
● The service was in need of some refurbishment. The registered manager told us the provider was working

to improve the environment for people. The carpets in some areas of the service was stained and there was a plan in place to replace them within the next few weeks.

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 as Good. At this inspection the rating has changed to 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

- People were not always supported in a person-centred way. People reported they did not always receive care in the way and the times they wanted it. Some people who required support were not able to go to bed and get up when they wanted to. They felt this was due to a lack of staff. One person told us they would like to improve their mobility, but they had not been given the support to do so. They said they would also like to go out occasionally, but this was not something that happened.
- People and staff told us although the manager was open and approachable, they did not always follow up and act on the issues raised to them.

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

- There was a lack of effective oversight of the service.
- Some aspects of care were not audited on a regular basis to ensure the quality of care was maintained. Some people's daily records were not being completed; this had resulted in a lack of information on the care people received each day. One person's care plan had not been updated since December 2021. There had been significant changes to the person's care needs and this lack of up to date accurate care records put people at risk of receiving unsafe care.
- There were no cleaning schedules in place at the time of our inspection. The registered manager told us a member of staff was developing these schedules. However, the lack of clear standards for staff to work against and maintain, resulted the concerns we reported on in our safe section of this report. This also prevented a robust auditing system of this area of care due to the lack of clarity over areas of responsibilities for staff undertaking cleaning duties.
- Although there were some quality monitoring audits in place, these had either only recently been introduced or were not completed correctly. This included a monthly medicines audit we viewed which had been completed and dated incorrectly. This lack of oversight resulted in audits not being completed correctly or in a robust way and any issues around the quality of care were not being identified.
- Although the provider had undertaken regular visits to the service, their provider monitoring processes had not identified the issues we found in relation to the quality of care at the service. This included the concerns we found with care records, nutritional needs and mental capacity assessments. Consequently, these issues had not been addressed.

The provider had not ensured effective governance of the service. This was a breach of regulation 17 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People did not always feel engaged in the running of the service. Two people we spoke with told us there had recently been a garden fete at the service and they had not been made aware of the event. One person said "I don't always get to know what is going on. I don't always get (taken) down to activities."

● People told us there were regular residents' meetings and they were able to voice their opinions. However, there was a lack of information to show people's opinions and choices had been acted upon.

● The majority of staff we spoke with did not feel their opinions were acted upon. Most staff told us the registered manager was approachable, but very little changed when issues were raised to them. Staff felt staff morale at the service was low and this had been impacted by the lack of staff. The registered manager was aware of the issues around staffing and told us they continued to work with the provider to improve staffing by looking at deployment and recruitment.

Working in partnership with others

● The registered manager did not always work in partnership with other health professionals. This included, as reported in the safe section of this report the lack of referrals made or support requested from the SALT team.

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 understood their responsibility in relation to the duty of candour. They and the provider had undertaken investigations where complaints had been raised and when issues occurred at the service.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider was not working in line with the principles of the MCA. Where required applications for Deprivation of Liberty Safeguards for individuals had not been made |

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 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People using the service were not always protected from risks to their safety. Assessed measures to support people were not always in place and some individual and environmental risks to people's safety had not been robustly assessed. |

**The enforcement action we took:**

We issued the provider and registered manager with a warning notice.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>There was a lack of effective oversight of the service by both the registered manager and provider. Quality monitoring processes were either not in place or not being used effectively. |

**The enforcement action we took:**

We issued a warning notice to the provider and registered manager

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff levels did not always meet the needs of service users. Staff were not supported by adequate numbers of ancillary staff. |

**The enforcement action we took:**

We issued a warning notice to the provider and registered manager