Care Quality Commission

Leonard Cheshire Disability

Westmead - Care Home Physical Disabilities

Inspection report

Westmead Close
Saunton Road,Braunton,
EX33 1HD
Tel: 01271 815195
Website: www.example.com

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 19 March 2015 and was unannounced. At the time of the inspection there were 19 people living at Westmead.

Westmead is registered to provide support and personal care for up to 19 people. It is not registered to provide any nursing care. They provide care and support for people who have physical disabilities and learning disabilities.

The service does not have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The last manager deregistered in March 2015 due to the fact she was also managing a children's service with the same provider and the children's regulator OFSTED were not satisfied with the management arrangements. The provider had put in an interim management arrangement

Summary of findings

of having one of their other registered managers overseeing this and their own service. This manager splits their time equally between the two services. The operations manager said they were interviewing for a manager on the day of the inspection and hoped to have a new one in place very quickly.

Following the previous inspection carried on 15 April 2014 we found areas of improvement were needed in staffs understanding of the Mental Capacity Act 2005 (MCA) and how this translated into practice, their understanding of reporting any safeguarding concerns. The service did not have systems to check that care plans were being kept up to date. The service sent us an action plan about what they intended to do to ensure they would make these improvements. At this inspection it was clear staff had received additional training in MCA and safeguarding protocols. Care plans and reviews were taking place on a regular basis and this was being checked as part of the registered provider's monthly checks.

At this inspection we found improvements were needed to ensure there was sufficient staff on duty at all times to meet people's needs, including their social and emotional needs. People said they did not always feel safe as there were times there were not enough staff on duty. Comments included "When they are fully staffed I feel safe, when there are only three staff you know they are on their feet all day and they haven't got time. In January and February I had to keep waiting for a drink, I was told I had to wait because they were busy."

Staffing levels have affected the quality of activities and access into the local community. People reported there were often limited opportunities for them to leave Westmead to go into the community. Plans were being put in place for people to go swimming and some people had been assisted to have some short breaks, but others had not been offered opportunities to go out for weeks, despite this being part of their goals within their care plan.

Although there were interim management arrangements in place, the provider needed to ensure a new registered manager was recruited, as this service has a long history of having no manager or managers who do not stay in post for very long. This has been unsettling for people and staff working there.

Whilst there was sufficient equipment for people to ensure their physical and communication needs were being met, people were still reliant on staff to open and close their bedroom door for them. There was no assistive technology being used to support people to enable them to open and close their own bedroom doors to enhance their dignity and privacy.

People said staff were supportive and understood their needs. One person said "They are very nice caring staff. If my door is closed staff will knock and wait until I say they can come in." Observation showed people were assisted in a caring and respectful way, although there were two examples of staff assisting people to eat where there was very little communication between the care staff and the person.

Staff were knowledgeable about people's needs wishes and preferred routines and received support and training to do their job effectively and safely. Staff said their views were listened to and they felt part of a team. Staff recruitment processes were robust and ensured staff were only employed once checks and references had been obtained.

Risks were being managed appropriately, assessments were in place and these identified how to reduce risks. Risk of falls, pressure damage, poor nutritional intake and moving and handling were risk assessed and kept under review on a regular basis and as people's needs changed. Where a risk had been identified, measures had been put in place to reduce risks.

People were supported to maintain a balanced diet and where needed special diets were catered for. People's health care needs were closely monitored and staff worked closely with healthcare professionals such as physiotherapists.

Systems ensured the views of people and staff were included as part of the overall quality monitoring and checks were completed on records, environment, medicines, training, accidents and incidents so ensure the service was safe and effective.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe. This was because there were not always enough staff on duty to meet the number and needs of people living at the service.

Staff understood how to support people to ensure they stayed safe and recruitment processes were robust.

Medicines were administered, stored and recorded appropriately, although this was reliant on staff checking each person's folder as prescribed medicines for each person was not held in a central folder.

Requires improvement

Is the service effective?

The service was effective. Mental capacity assessments were in place where relevant and staffs' understanding of how to protect people's rights had improved.

Staff had a good understanding of people's needs and training had been completed or planned to enhance their skills.

People's healthcare needs were being well managed and people were supported to have a balanced diet.

Good

Is the service caring?

The service was caring. People were mostly positive about the care they received and this was supported by our observations.

Dignity and respect was maintained for people when the right staffing levels were in place.

Good

Is the service responsive?

The service was not always responsive because people had limited opportunities to go out and about or try new activities.

Staff were working towards making people's care plan information more personalised. Staff knew people's preferred routines to enable them to deliver care in a person centred way.

People's concerns and complaints were dealt with swiftly and comprehensively.

Requires improvement

Is the service well-led?

The service was not always well- led because they did not have a registered manager in place, although the provider had put in some interim arrangements, this was not full time.

Requires improvement

Summary of findings

Quality systems ensured people and staff views were listened to and the environment was well maintained.

Westmead - Care Home Physical Disabilities

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Prior to the inspection we reviewed a range of information to ensure we were addressing potential areas of concern and to identify good practice. This included the Provider Information Record (PIR), which asks the provider to give some key information about the service, including what the service does well and improvements they plan to make. We also reviewed previous inspection reports and other information held by CQC, such as notifications. A notification is information about important events which the service is required to tell us about by law.

The inspection took place on the 19 March 2015 and was completed by two inspectors. We spent time talking with 9 people who use the service and observed how care and support was being delivered by staff. We also spoke with eight staff including the interim manager, cook, team leader and care staff. We looked at four care files and records relating to medicines as well as three staff recruitment files and other records relating to complaints, quality monitoring and staff training records.

Following the inspection we spoke with one healthcare professional and asked the provider to send us further details about how complaints had been managed and resolved.

Requires improvement

Is the service safe?

Our findings

People said they did not always feel safe. One person said "When they are fully staffed I feel safe, when there are only three staff you know they are on their feet all day and they haven't got time. In January and February I had to keep waiting for a drink, I was told I had to wait because they were busy". "When short staffed I do feel vulnerable." Another person said ''I am angry they had only three staff on this weekend and it is not safe.'' Others people were more positive and said "I feel safer than I have done for a long time. I get on better with older staff .''

Staff confirmed there had been some shifts over the weekends in particular when, due to staff sickness there had only been three staff on duty to meet the needs of 19 people with complex physical and healthcare needs. One staff member said ''It has been tough for residents at times as we have been short staffed which means we have to ask people to wait for their personal care and we can't take people out and about with so few staff.''

We fed back people's concerns to the interim manager and also to the operations manager and heard that the expected staffing levels should be five or six staff on for the morning shift and five staff for the afternoon shift. The staff rotas showed in recent weeks on three weekends this level of staffing had not been achieved due to staff sickness and inability to find cover for shifts. The manager said staff had been able to request agency cover at short notice, but this had not appeared to have happened on the previous weekend where there were only three staff on duty. The rota showed that there should have been four staff, which was already a short fall of two staff from the expected levels. There was no evidence of a dependency tool being used to determine the staffing levels. The interim manager was new to this service was unsure how the levels had been determined.

The impact of not having enough staff on the weekend shift was that people's needs were not always met in a timely way and with three staff on duty the service could not guarantee people's safety and wellbeing. Most people living at the service required two staff to safely move them for all aspects of their personal care.

We found that the registered provider had not protected people against the risk of not having enough staff on duty at the home. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed medicines being administered over the lunch time period by the senior member of staff working on the shift. They said staff with responsibility for administering medicines had annual medicine administration training from the chemist dispensing the medication. Medicines were kept in a locked cupboard in the person's room. The key to the cupboard was kept in locked cupboards that only staff had access to.

A monitored dosage system (MDS) was used for tablets to be administered and each person had a medicines folder, both the medicines and folder were kept in the locked cupboard in the person's room. On the cover of the medicine folder there was a picture of the person, their name and date of birth, details of the chemist that dispensed the medicines and the person's GP details. This information helped to ensure medicines were given to the correct person.

The folder contained a medicines administration record (MAR) printed by the pharmacy and a list of staff that administered medicines which included their initials (as used on the MAR), their signature and date. The folder also contained a medicines weekly check. This included areas such as pre-administration daily check, storage, stock rotation, unexplained omissions on the MAR, noting of any medicine administration errors, disposal and drug fridge temperature.These were audited as part of the providers monthly checks. A record of the person's current medicines, the frequency, route, description of medicine, side effects and contraindications and the organisations' medicines policy were also held in the folder.

All tablets for a person were "popped" from the monitored dosage system into a plastic pot and given to the person to take (each pot was used only once). If the person was unable to take their own tablet the member of staff gave the tablet to the person in the best way to suit the person's needs; for example on a spoon with some jam, for someone with swallowing difficulties. Any liquid medicines were measured into a plastic pot before giving to the person. We noted the process was not rushed and the member of staff administering medicines ensured they

Requires improvement

Is the service safe?

were taken and then signed the medicine administration record. However, there was little communication with the person from the member of staff whilst giving the medicines.

The member of staff collected the key to the person's medicine cupboard and then went to the person's room and collected the medicine and medicine folder and then went to find the person to give them their medicine. Each person's prescribed medicines were held in individual folders in each of the bedrooms. This meant a person's medicine could be missed if the member of staff was new to the process and did not check the medicines administration record in each person's room. We fed this back to the manager who said she was looking to address this by having a central list or folder for all medicines being used in one place so staff would have one central place to check as a safety measure.

Risks were being managed appropriately, assessments were in place and these identified how to reduce risks. Risk of falls, pressure damage, poor nutritional intake and moving and handling were risk assessed and kept under review on a regular basis and as people's needs changed. Where a risk had been identified, measures had been put in place to reduce risks. For example one person was assessed as being at risk of poor nutritional intake. Their food and fluid offered and taken was closely monitored each day to ensure they were eating and drinking sufficient amounts. This included additional fortified drinks to add calories and nutrition to their diet.

People had equipment to suit their individual needs. These had been assessed and maintained by healthcare professionals such as physiotherapists. Where people required equipment to assist them to be comfortable either in a sitting or laying position, there was detailed descriptions and photos to assist staff to support people to be positioned correctly.

Staff showed a good understanding of the various types of abuse and they knew who and where they should go to report any concerns they might have. For example, staff knew to report concerns to the registered manager, provider and externally such as the local authority and the Care Quality Commission (CQC). Staff had received training in the safeguarding of vulnerable adults as at the previous inspection staffs' understanding of the process was variable.

There was evidence to show the service learnt from accidents and incidents. For example there had been an accident where one person had been scalded by a hot drink. There was clear information at the drink station for staff to follow which had been devised following this accident. It reminded staff, drinks should be cooled with milk or water and gave photos of the types of cups each person could safely use if their movements were restricted.

There were appropriate recruitment procedures that ensured staff were safe and suitable to work in the home. Recruitment files showed all staff had completed an application detailing their employment history. Each staff member had two references obtained, and had a Disclosure and Barring Service (DBS) check completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable people.

Good

Is the service effective?

Our findings

At the last inspection we found there was a lack of understanding of the Mental Capacity Act 2005 (MCA) and how this applied in practice to protect the rights of people living at the service. Since this inspection CQC had received an action plan which showed how the service was going to provide further training to staff to assist them in their understanding of the act. During this inspection staff confirmed they had received training in MCA and in the deprivation of liberty safeguards (DoLS). The team leader explained that none of the people living in the service had been assessed as lacking capacity. Some people needed support to communicate their views and decisions and support to understand the choices being offered. No one was being deprived of their liberty and therefore no applications had been made for DoLS.

Observations of how care was delivered showed people's consent was gained before support was undertaken. People said staff were good at ensuring their consent was gained. One person said "Staff take time when doing personal care; they do this very well". They would say would you like a wash today". They went on to say "if 'I said no they would respect this but would come back later to check I was alright." However, another person said "Staff usually ask consent but sometimes they don't". They went on to give an example of a member of staff lowering their bed without telling them why they were doing this.

There was sufficient equipment to ensure people's needs could be met. All bedrooms had tracking for hoisting equipment and en-suites were designed to allow people as much independence as possible. The one area where people lacked independence is in being able to open and close their own bedroom door. The service had not explored any assistive technology to assist people with being able to access their own rooms without having to call for support from staff.

Staff demonstrated a good understanding of people's individuals' needs and wishes. For example staff were able to describe who wished to get up early and who preferred to be supported at a later time. They had received training in all areas of health and safety as well as more specialised areas to enable them to support people with complex physical and health care needs. Staff said they had opportunities for learning and developing their skills to enable them to understand their role and be competent and confident in meeting people's needs. One staff member said they had not worked with younger adults with physical disabilities before but had been given good training in understanding how to use hoisting equipment and how to work with people to ensure this was done with dignity.

Staff had received supervision and appraisals to ensure they understood their role and had an opportunity to discuss their training needs. This process had been delayed due to the absence of a full time manager, but was now back on track with appraisal dates completed or booked in.

Care files showed people healthcare needs were being closely monitored and where needed referrals were made for specialist input. For example records showed the staff team had often referred to the physiotherapist for advice and guidance for people's changing needs. People confirmed they were able to see their GP or other healthcare practitioner's when needed. One person said "Staff responded very quickly when I was unwell. They rang 111 and were told to get an ambulance". They also said they had been unwell the day before our inspection and had been looked after very well.

People were supported to eat and drink throughout the day. Where risks of poor nutritional intake had been identified, food and fluid charts were used to monitor what the person had each day. Observations of the lunchtime showed there were some staff who supported people to eat and drink in an engaging way, whilst there were two examples of where staff did not engage the person in the task and there was very little talk or discussion between the care worker and the person being assisted.

There was a range of equipment to enable people to eat independently, such as specialist cutlery and plate guards. Where people needed their meal to be a specific consistency due to their particular needs, this was clearly identified on a list held in the kitchen. The cook explained how she made sure each meal suited people's individual needs. People were offered a choice and variety of meals. People said they were satisfied with the meals and choice of food and drinks being offered. One person said "The new cook is fantastic. Nicely presented food and not too much but I can ask for more if I want it". Another explained they could make drinks whenever they wished and they could talk to the cook about their likes and dislikes and would get alternatives

Good

Is the service caring?

Our findings

Most people said staff were caring but there was also some negative feedback. One person said “Some new staff need to be told we are not kids”. They went on to say a member of staff called them childish names such as “lad’’ and “boy” they didn’t like and gave other examples of ways they felt they had been treated inappropriately, such as being told “silly jokes” they thought were not appropriate. The person told us they told the member of staff they were not happy with the way they had been treated. They had also informed the manager of the concerns and the manager had told them to report any further incidents to her. Another person said ''Pleasant staff; don’t get on with some staff but the majority I do. Staff would knock on my door and wait until I say come in”.

People felt their dignity and privacy was upheld. One person said “They are very nice caring staff. If my door is closed, staff will knock and wait until I say they can come in.’’ Staff were able to describe ways in which they worked to ensure people’s privacy and dignity was maintained. One staff member said ‘‘We sometimes have to encourage people to allow us to assist them with their personal care, we do this in a way which does not embarrass them.’’

Observations of the way staff worked with people supported this. Following lunch for example, people were assisted to clean their hands and face in a kind and discreet way, to promote their dignity.

People were supported to make decisions and choices using a variety of communication. Assistive technology was used for people who were unable to verbalise their views and staff had a good understanding of people’s non-verbal cues to help them to understand what choices people were making. For example, in care plans there were examples of what facial expressions or eye movements indicated yes or no for some people. One person said “Most staff explain things properly.” One person told us staff supported them to understand difficult decisions and gave them time to think about their response.

People were supported to develop and maintain positive relationships with their friends and family. One person said they had been supported to visit new places and make friends with similar interests and diversity. Staff talked about how they had been supporting someone who had recently had a bereavement, showing kindness and compassion for the person’s feelings. One staff member discussed the death of a person at the home and how this had affected people and staff. They said some people had wanted to talk about their feelings whilst others needed time on their own or an ‘‘extra hug and a bit of TLC.’’

Requires improvement

Is the service responsive?

Our findings

At the last inspection we found care plans had not always been reviewed with the person they concerned. During this inspection people said they had been involved with the review and development of their plans. One person said "I was involved quite a lot in my care plan. Staff listened to me and heard what I wanted to say; very much so….. There is a review of my plan and I am involved in this." Another person said "I was involved in writing my care plan; it was a meaningful involvement. I am involved in the review of my plan and I think it is an annual review." One person did comment that their annual review had involved too many people and said they felt "out of the picture." This had been their commissioning review.

Care files contained details of people's needs and covered all aspects of their personal, health and emotional wellbeing. This had been developed from a pre admission assessment and also information made available from the commissioning teams about people's assessed needs. Where a particular need had been identified, a care plan was available which was individual to the person and their particular need. For example where a person was at risk of developing pressure sores, an agreed routine of regular bed rest had been set up with specific instructions for staff about how to assist the person to position them on their bed to relieve pressure areas. Another person's care plan gave detailed information about the preferred morning and evening routines. This assisted staff to deliver care in a person centred way.

One care file identified an area for further development as being assisting the person to have more trips out into the community. This had not occurred due to staff shortages. It was noted that the optician had visited the home to see this person, when they may have benefitted from a trip out to have their eyes checked as part of a trip into the local town. Other people said they would have liked to have gone out more. One person said "I am not able to go out as often as I would like it depends on how many staff. I didn't go out at all last week." One person told us they did voluntary work, lots of craftwork and played games on the computer. They said they had a computer in their room but did not have internet access but they could access the internet in the computer room. Although activities had been planned, most of these were in-house with limited opportunities to access the local community in recent months due to staff shortages. One person said they had been able to go out independently, but for people who required support, this had been limited.

The complaint's policy sets out the procedure to be followed by the provider and included details of the provider and the Care Quality Commission. People said they were able to make their complaints known to the manager or staff. One person said ''I have been to see the manager about staff shortages and they are trying to employ more staff.'' This complaint was recorded including the response to the person who raised the complaint. Another person said ''We have meetings sometimes to discuss any issues or you can talk to your keyworker.''

The complaints log was stored electronically and when this information was initially requested, there was no outcome of how each complaint had been investigated. The interim manager did find this information, but it was not all stored in one place for easy reference. Complaints had been dealt with within a reasonable timeframe, issues had been investigated and responses given. For example one person had complained they did not feel their needs were being met by staff and they needed more assistance with their finances. This complaint was upheld; the person received an apology and an agreement for staff to provide more support. The provider employed an independent person to come and talk with people on a monthly basis about any concerns or what's working well.

Requires improvement

Is the service well-led?

Our findings

There was no registered manager in place. The previous registered manager had needed to de-register as they were also the registered manager of a children's service in Exeter and the children's regulator OFSTED were not satisfied with the management arrangements. The provider had an interim management arrangement of having one of their other registered managers overseeing this and their own service. This manager splits their time equally between the two services. The operations manager said they were interviewing for a manager on the day of the inspection and hoped to have a new one in place very quickly. We may take further action about this if CQC do not receive an application to register a new manager.

People said they were not happy with the fact they did not have a registered manager in place. One person said "They need to stop relying on managers out of the area; it is really bad they didn't get a manager before Christmas. The manager went off sick for a very long time." People were aware of who the current interim manager was. One person said "We don't have a permanent manager at the moment but a manager comes two or three times a week."

Systems were in place to ensure there were audits to check the environment was maintained safely, medications were monitored and care files and daily records were accurate and up to date. The manager said they had a system of other managers from the same provider completing audits in each other's homes. The monthly visits recorded what was looked at and what actions were needed. For example the last audit completed identified a matrix would be useful for identifying when staff had received their supervisions and when the next one was due. The manager had actioned this to ensure staff had regular support and supervision sessions.

People confirmed their views were sought about the running of the service, as individuals and as a group at in house meetings. The last meetings minutes showed people were asked if they knew what to do if they had any concerns or complaints. There were also regular relatives meetings. The last meeting recorded that there had been a concern about supporting a person for a hospital admission. As a result of this concern a new protocol had been put in place for staff to follow if someone was admitted to hospital. This showed the service acted on complaints and concerns.

Staff understood the ethos of the service was to promote people's independence and enhance their skills and learning, although in practice, due to low staffing numbers this was not always easy to put into practice.

Staff said they had opportunities to contribute to the running of the service. There were staff meetings which were recorded for those unable to attend. Staff said their views were listened to and they could make suggestions to improve care and support. One staff member said ''We work well as a team, with more new staff coming on board this is important. We are able to talk about our views and we share what we think works well for people every day in our handover.''

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: People who use services and others were not protected against the risks not having sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.