Four Seasons Health Care (England) Limited

Westroyd Care Home

Inspection report

Tickow Lane
Shepshed
Loughborough
Leicestershire
LE12 9LY

Tel: 01509650513
Website: www.fshc.co.uk

Date of inspection visit:
19 July 2017
20 July 2017

Date of publication:
25 September 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected Westroyd Care Home on 19 July 2017. This was an unannounced comprehensive inspection. We returned on 20 July 2017 to carry out a second day of inspection which was announced.

Throughout May and June 2017 we received a number of concerns about the service. This inspection was carried out in response to the concerns that had been raised. These included a lack of staffing, staff not being fully trained, people being got up very early against their wishes, poor maintenance of equipment in the premises and concerns that people were not being kept safe.

At our last inspection on 7 February 2017 we found a breach of regulation 12 safe care and treatment. After this inspection the provider wrote to us to say what actions they would take to meet legal requirements in relation to this failure to provide safe care and treatment. At this inspection we found the provider had made most of the required improvements in relation to this breach. However we found that further improvements were required and additional breaches of the regulations were identified.

Westroyd Care Home provides care for up to 55 people who require residential care without nursing. The home had two separate buildings; the House and the Lodge. The House provides care to people who have needs associated with older age. The Lodge provides care to people who are living with dementia. Each building had two floors. There was a communal lounge, dining room and kitchen in each building. At the time of inspection there were 44 people using the service.

The service had a registered manager. 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.

People were not consistently protected from the risk of abuse at the service because incidents had not always been reported appropriately so they could be investigated. Staff had received training in safeguarding adults and knew how to report concerns.

People were not consistently protected from risks relating to their health and safety. Assessments of people's needs had not been completed fully. There was a lack of consistency in the information that had been recorded in assessments of need, care plans and risk assessments. Risks associated with some people's care needs had not been fully assessed. Guidance for staff was not detailed to ensure staff knew how to meet people's needs safely.

Medicines practices had improved. Staff were trained and deemed competent to administer medicines. However, a concern about inhaled medicine had not been identified, and charts to record where cream needed to be applied were not used consistently.

Equipment people used had been checked to make sure it was safe. Equipment that was used as part of the service such as a washing machine were not maintained appropriately and were not always fixed in a timely manner. Areas of the service people did not access were not kept clean. Appropriate infection control measures were not always used.

There were not enough staff to meet people's needs. People had to wait for support and staff left people to ensure others remained safe. Staffing levels had been assessed. This was not based on all people's actual needs as these had not all been identified.

People were supported to access healthcare services. People had a choice of meals. Where people needed a specific diet such as low sugar or soft this was not always identified or provided. Records to ensure people at risk of dehydration were not always completed correctly.

The provider had safe recruitment practices. They checked staff for their suitability before they started their employment. Where this had not happened it had been identified and measures put in place to carry out relevant checks.

Staff received support through a structured induction and supervision. There was an on-going training programme to provide staff with guidance and update them on safe ways of working.

The registered manager had an understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Assessments of mental capacity had been completed. However, the information that had been recorded was not based on the specific decision.

People were asked to make choices about their care and staff asked people for consent before they supported them.

People told us that staff were caring. However we observed a number of interactions where staff did not show this behaviour. People were not always treated with dignity and respect.

People had most of their needs assessed and a care plan developed from this. The information in these was not always consistent. Care plans had been reviewed monthly. These had not always been reviewed in response to an incident which could identify a change in a person's needs.

People took part in some activities that they enjoyed. Activities were not always provided in the House due to the availability of the member of staff who provided these.

There was a complaints procedure in place. People and their relatives felt confident to raise their concerns. Some relatives felt that their concerns were not listened to.

The provider had systems and processes in place to identify and reduce risks to people who used the service. These had not been used effectively. We found concerns during this inspection that had not been identified by the registered manager and had not been picked up through the processes in place.

People had been asked for their feedback of the service and had attended meetings with the provider to discuss concerns. The most recent meeting had been held at short notice and relatives felt they were not given opportunity to attend.

People and staff felt they had received a good service until recently. The service was led by a registered

manager who understood most of their responsibilities under the Care Quality Commission (Registration) Regulations 2009. Staff did not always feel supported by the registered manager.

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

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This could lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not consistently protected from risks relating to their health and safety. Risks were not always identified.

Measures were not in place to enable staff to support people safely.

People were not always protected from the risk of abuse.

There were not enough staff deployed to meet people's needs safely. The service followed safe recruitment practices when employing new staff.

Premises and equipment were not clean and maintained appropriately.

People's medicines were given to them as prescribed. However, issues were identified with the dosage of inhalers. Staff were trained and deemed as competent to administer medicines.

Is the service effective?

Requires Improvement

The service was not effective.

Capacity assessments had been completed when a person's ability to make a specific decision was in doubt. However, the information in these was not always relevant to the decision.

People were supported to access healthcare services. Where people needed to follow a specific diet this was not always provided.

Staff received support through an induction to the service and supervision. Staff had completed training. People felt staff were well trained.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us they received support from staff who were caring and kind. However, some interactions between staff and people did not always show these behaviours.

People were not always treated with dignity and respect. Staff did not always support people appropriately to ease their discomfort.

Staff knew people who they worked with regularly well and were able to tell us about their likes and dislikes.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had some of their needs assessed and a care plan was developed from this. However, the information was not always consistent or reflect the needs of people.

There were activities that people participated in. However, these were not always provided at the House.

There was a complaints procedure in place. People felt confident to raise any concerns..

Is the service well-led?

Inadequate

The service was not well led.

The provider had systems and processes to monitor the risks to people using the service. These had not been effective in identifying risk, or reducing this to avoid the likelihood of reoccurrence.

Actions had not been taken to ensure that people received a good quality, safe service.

Staff did not always feel supported in their role. They felt that they were not always listened to.

People had been asked for their feedback of the service. A meeting had been held to provide feedback to people and their relatives following concerns. However, people felt this was arranged at short notice and they were not able to attend.

Westroyd Care Home

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.

This inspection took place on 19 July 2017 and was unannounced. We returned on 20 July 2017 and this day was announced. The inspection was carried out by two inspectors, a specialist nurse advisor, a pharmacist inspector 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. The expert had experience of caring for someone who used this type of service.

Before our inspection, we reviewed the information we held about the service and information we had received from people, relatives and staff who had contacted us. We contacted the local authority that had funding responsibility for some of the people who used the service.

We reviewed a range of records about people's care and how the service was managed. This included nine people's plans of care and associated documents including risk assessments. We looked at four staff files including their recruitment and training records. We also looked at documentation about the service that was given to staff and people and policies and procedures that the provider had in place. We spoke with the registered manager, a unit manager, the regional manager, ten care workers, an agency member of staff, a pharmacist from the provider, an activities co-ordinator, a maintenance worker, two cooks and a housekeeper.

We spoke with seven people who used the service and nine relatives. This was to gather their views of the service being provided. We observed staff communicating with people and supporting them throughout the day.

Inadequate

Is the service safe?

Our findings

At our last inspection carried out on 7 February 2017 we found one breach of the Regulations; Regulation 12 Safe care and treatment. We required the provider to make improvements and they submitted an action place setting out what they were going to do.

At this inspection we found that the provider had made most of the required improvements. However we found areas where improvements had not been made. We also identified new areas of concern.

People were supported with receiving their medicines and some people had support using inhalers. We observed this medicine being taken. After this had been done the monitor on the inhaler recording doses given had not changed. This was discussed with the person administering medicines and a pharmacist who worked for the provider. It was agreed only one inhaler was in use and from the monitor on the inhaler it would appear that people were not receiving the correct dose of their medicine. The regional manager discussed this with us following the inspection. They told us they had found that the monitor was not recording doses correctly and this was going to be discussed with the dispensing pharmacist. The regional manager also told us that two inhalers were in use and not one as agreed with the member of staff dispensing the medicines. It was not possible to determine that the medicine had been given as recorded. This had not been identified through the checks completed by the provider on medicines and this put the person at risk of not receiving their medicines as prescribed.

People were supported with prescribed creams being administered. At our last inspection topical medication administration record charts (TMAR) were used. These use a chart to demonstrate to staff where creams should be applied. TMAR charts were being used effectively in the House. However, in the Lodge these were no longer in use. The regional manager told us that staff were using instructions recorded on Medicine Administration Record (MAR) charts. These are printed charts with written instructions and are not as detailed as TMAR charts. People who lived in the Lodge were living with dementia. Staff told us that people did struggle to tell them where cream needed to be applied. Staff who administered medicines were not always permanent staff who knew people and their needs well. People were at risk of their cream not being applied correctly.

Information was recorded in people's care plans and MAR charts about their allergies. One person had been prescribed a medicine which had an ingredient in they were allergic to. This had not been identified when the medicine had been prescribed or by staff who had administered it. The person had received the medicine for three days. We discussed this with a pharmacist who worked for the provider. They put in place measures to avoid this happening again on the second day of our inspection. These included a poster to remind all staff administering medicines to check they did not include ingredients people were allergic to.

Risk assessments were not always completed for areas where there may be risks to the person when they were receiving care. For example, one person was at risk of falling. They had a sensor in place to alert staff if they got out of bed. The person moved the sensor so that it was not always picking up their movements. This had been identified in their care plan. However, there was no risk assessment in place. Staff were

supposed to check the sensor was in the correct location each time they went into the person's bedroom. Daily monitoring charts showed that this was completed less than 50% of the times that staff went into the person's room. The measures in place were not effective at ensuring that the risk to the person was known and reduced.

Risk assessments that were in place were not reviewed to ensure their effectiveness following incidents. One person's risk assessments had been reviewed monthly. They had a fall that resulted in a serious injury. Their risk assessment was not reviewed following this to ensure that the measures in place were still suitable to reduce the risk of the person falling. Information about the risks to people was not shared effectively between staff in the service. One person had been diagnosed with diabetes. This information was not identified in the kitchen and the cook was not aware of the person's need for a diet that was suitable for diabetics. The person was at risk of being given food that was not appropriate for their health needs.

People did not always have a care plan detailing their needs or risk assessments about how to support people safely. One person had moved to the service in May 2017. They did not have a full care plan in place. The person presented behaviour that could be classed as challenging. This put themselves at risk. The behaviour also put other people at risk due to presenting a trip hazard in communal areas and in doorways. There was no assessment in place about this behaviour, or guidelines in their care plan for staff to follow to support the person safely. A member of staff commented, "If [person's name] is going to hit another resident we fill in a distress chart. We have not been told how to deal with it." There was no risk assessment to try to reduce the risk to the person and to other people. We discussed this with the registered manager. They told us they were completing a full assessment and had contacted the funding authorities to ask them to assess the person. Measures were not in place at the time of inspection to reduce the risk to the person and to others. An assessment of the person's behaviour had not been undertaken to provide staff with guidance on how to meet their needs safely.

Measures that were in place to protect people from harm were not always followed. One person had been diagnosed with being at risk of injury to their skin. They had a control measure in place to use a pressure cushion when they were sitting in chairs to reduce the likelihood of their skin becoming injured. We saw that the cushion was not used during our inspection when the person was sitting in a chair in the lounge. We discussed this with the registered manager. They told us that they would remind staff the importance of using this equipment.

People were not protected when incidents happened as these were not always reported correctly to allow investigations to take place. There were four incidents that were recorded within the daily notes for two people. These had not been recorded on the provider's incident reporting system (datix) or reported to the registered manager.

People were not protected from the risk of infection. On the first day of our inspection we were told by a member of staff a person had been diagnosed with Clostridium Difficile which is an infectious disease. We had not been made aware of this and there were no signs around the service, or protection measures in place to reduce the spread of this. We discussed this with the registered manager. They told us that the confirmation of the diagnosis had only been made that afternoon. The test had been taken one week previously and control measures had not been put in place until the confirmation had been received. Infection control measures should be used when an infection is suspected in order to reduce the likelihood of this spreading. On the second day of inspection we saw that a sign was in place to inform staff to use appropriate measures to reduce the spread of infection and protective equipment was also in use.

These matters constituted a continued breach of Regulation 12, Safe care and treatment of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risk of abuse. The provider had a system in place for identifying and reporting potential incidents where a person was at risk of abuse. Staff we spoke with demonstrated an understanding of potential types of abuse of reporting these. However, we found four incidents of potential abuse that had been recorded in daily notes. One person had unexplained bruising noted on three separate occasions. This had not been investigated to determine the cause and to see if any measures were needed to keep the person safe. Another person had been kicked by on the shin by someone who used the service. As this was not reported this behaviour was not identified as a possible risk to other people who used the service. The daily notes were not checked by a member of the management team as the process for staff to follow was to record incidents on the datix system. These incidents had not been reported correctly to the registered manager, investigated or reported externally to allow the local authority to consider if they needed to investigate. The registered manger told us that they would discuss the importance of using the correct recording systems with staff so that incidents were properly investigated. These had not been recorded appropriately using the system that was in place. The registered manager was not aware of the incidents. They had not been investigated or reported to external professionals. The provider has a duty to report these incidences to the local authority and to CQC in accordance with statutory notification procedures. The registered manager told us they believed that staff understood how to use the system to record these incidences appropriately. Staff had documented the incidents but had not used the system in place. There were no checks undertaken of the daily notes to review the content. We found the incidents through review of the daily notes. We checked with the registered manager and these had not been recorded on the datix system. The processes that were in place were not operated effectively to ensure that people were protected from abuse.

These matters constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

People told us that there were not sufficient numbers of suitably qualified, competent and experienced staff to meet the needs of people who used the service. One person said, "It can be a bit light on the staff. That is as many as they can get at that particular time. Another person told us, "We are very short staffed here. That's the problem. When they have days off they are short staffed and then they get agency." One person commented, "I wanted a bath and there was no one to help me. I told [registered manager] we are short staffed." A relative said, "There have been times when we have been in the lounge with a number of people and there is no carer in there at all." Another relative told us, "I have always been concerned about staffing. It has been exacerbated due to [person's name] and [person's name] moving in. The carers can't cope."

Staff told us they felt there were not always enough staff. Comments included, "There is not enough staff, everyone is flogged." "The staffing levels in the week are better. We struggle at the weekend," "There is not time to do anything. We can't always get the toileting done. It makes me on edge," and, "Staffing is not always good. We have six people who use the hoist here." The registered manager told us they had put an additional member of staff on duty during the day to improve staffing levels. This had been implemented in the last week. In the House the staffing levels that had been assessed as being necessary by the registered manager were in place. People were supported when they asked for assistance and were not left waiting for support. However, we did see one person ask to go to the toilet. The member of staff responded by saying, "You will have to wait because there are only two of us on the floor." The person did wait for eight minutes before being assisted to the toilet.

In the Lodge people needed additional support and assistance. One person required one member of staff with them during times when they were presenting behaviour that put themselves and others at risk. People

did ask for support and were politely asked by staff to wait while they were assisting other people. One person got up and started to walk out of the room without staff. They had been assessed as needing support when walking due to the risk of them falling. Staff had to move away from the person they were assisting in order to ensure the person's safety while they walked. During lunchtime the activities co-ordinator also provided assistance. Even with the additional member of staff observations showed that staff regularly moved from supporting one person to another. Staff were not able to sit with on person and offer them assistance with eating their meal. People were left waiting for staff to return to them. One person poured their drink onto the floor, another attempted to pour their drink onto their meal. One person attempted to put salt into their eye. Staff had to monitor what was happening and respond. People who needed assistance to eat their food were left waiting for staff for return to them.

During the afternoon of the first day of our inspection a member of staff had to leave a person who was displaying behaviour that put themselves at risk in order to assist another person who needed the toilet. The person became upset and was asking for help. Staff were not available to assist them. The inspector had to offer reassurance and find staff to support the person. The staffing levels in place were at the level that had been agreed by the registered manager. The number of staff available was observed to not meet people's needs safely.

These matters constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

People and their relatives told us that the premises and equipment were not always clean or maintained appropriately. A relative said," There is only one machine working. It means that there was a big backlog of laundry. Residents are running out of clothes. [Laundry person] is fantastic. It has been awful the last three weeks." Another relative told us, "They didn't have any aprons last week. They were all dirty. People had plastic aprons on." There had only been one washing machine in use for a three week period. A new washing machine had been delivered recently. During our inspection we visited the laundry and found that there were two machines working. The member of staff in the laundry told us that two new machines were supposed to have arrived but only one did. The flooring in the laundry was torn and dirt was noted within the tears. People's clothes were on the floor waiting to be washed. Red bags had been used to separate washing where people may have been incontinent. These are designed to be sealed and then put in the washing machine where they disintegrate. This reduces the likelihood of cross contamination and is hygienic for staff handling washing. Red bags had not all been sealed and clothes were falling out of these.

A quilt had been left on top of the washing machines for three days. This was soiled with faeces. The washing machines were used for the time the laundry assistant was at work. However, they told us that they did not have the equipment in order to complete the laundry for all people who lived at the service in a timely manner.

The water boiler in the Lodge had been broken for between 7 – 10 days. We were made aware of this through relatives who had contacted us. At the time of our inspection the boiler had been replaced and there was hot water available. It was confirmed that the boiler had been broken and parts of the Lodge did not have hot water. A relative told us that their relative had not received a shower for seven days. A member of staff told us, "The boiler was on its way out for months." All people had received a bath or shower recently on the day of our inspection. The equipment had not been properly maintained, renewed or replaced.

These matters constituted a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Premises and equipment.

People told us they felt safe while receiving care from staff at Westroyd Care Home. One person said, "I feel very safe here." A relative commented, "I am quite happy that [person's name] is safe." However, other relatives were concerned that people were not safe. A relative said, "We have an accident waiting to happen." Another relative told us, "We are worried to death about [Person's name] and others. It has been awful over the last three weeks." Staff told us they had received training in how to keep people safe and records confirmed this. One staff member said, "I would stop anything immediately and report it." Some staff felt that needed to report their concerns externally instead of the registered manager. One member of staff told us, "I would report any concern to safeguarding or CQC." The actions staff described were in line with the provider's guidance where they would report to the registered manager or senior member of staff.

Guidance was in place for staff to keep people safe in the event of an emergency. There were plans in place so that staff knew how to evacuate people from the service should they need to. There were also plans in place should the home become unsafe to use, for example in the event of a flood. However, as staff were sometimes from an agency and did not work regularly at the service there were times when the guidance was not followed fully. Procedures to follow in case of a person becoming unwell had not been followed during a night shift in June 2016. This had been raised as a concern by external professionals. However, as the correct actions were not in place an investigation had to be carried out to ensure that the person had not been put at risk.

People were cared for by suitable staff because the provider mostly followed safe recruitment procedures. This included obtaining two references that asked for feedback about prospective staff and a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions and aims to stop those not suitable from working with people who receive care and support. These checks had taken place. However, we found that one person had been employed when they had not completed an application form. References had been sought although these had been provided by the member of staff and not from the previous employer directly. Two days before our inspection this had been identified and the regional manager told us they were completing the appropriate checks. They explained that the member of staff was not currently working in the service.

Where people used equipment such as hoists, the required checks had been completed to make sure that these were safe for people to use. Checks were carried out on safety measures in place, for example, fire alarms, as well as the temperature of the hot water to protect people from scald risks. Records showed that fire drills had taken place

.

People and their relatives told us they were supported with their medicines. A relative said, "The staff know how to give medicines." The provider had a policy in place which covered the administration and recording of medicines. We observed people taking their medicines and saw that staff followed the policy. Staff told us they were trained in the safe handling of people's medicines and records confirmed this. A pharmacist who was employed by the provider explained that agency staff did give medicines. They detailed the checks and training in place to ensure their competency before giving medicines. People had prescribed medicines to take as and when required, such as to help with any pain that they had. There were guidelines for staff to follow that detailed when these medicines could be offered to people. Medicine administration records had been completed correctly.

Requires Improvement

Is the service effective?

Our findings

People felt when they were supported by staff, they had the skills and knowledge to meet their needs. One person told us, "They have got a good core team who know what they are doing. They have all the skills." Another person said, "The agency staff come so often they are just slotting together." The staff know what to do." A relative commented, "They know how to look after [person's name]. They are experienced." Staff who we spoke with told us that they sometimes received training to help them to understand how to effectively offer care to people. One member of staff said, "I have done training in moving and handling and health and safety." Another member of staff commented, "We are meant to go online to check our training. We haven't had any for a while." One staff member told us, "I have asked for dementia training. I have not done any training in how to work with people who show behaviours. We are now working with people who display challenging behaviour." Training records showed staff had completed all basic training. For example, we saw that staff completed training in moving and handling and safeguarding. The registered manager told us staff had completed training that was based on supporting people with dementia. This was called resident experience training. The registered manager explained that this was an area that was being developed for all staff. One member of staff raised a concern about a number of staff who needed to complete the fire training. The registered manager told us they would ensure this training took place. Following our inspection they confirmed that all outstanding fire training had been completed.

New staff were supported through an induction into their role. Staff described how they had been introduced to the people who used the service and said they had been given time to complete training, read care plans and policies and procedures. They also said they had shadowed more experienced staff before working alone with people. Records confirmed this had taken place. The registered manager told us that they used the Care Certificate for new staff members. The Care Certificate was introduced in April 2015 and is a benchmark for staff induction. It provides staff with a set of skills and knowledge that prepares them for their role as a care worker.

People were supported by staff who received guidance in their role. There were processes in place to supervise staff to ensure they were meeting the requirements of their role. Supervisions are meetings with a line manager which offer support, assurance and learning to help staff to develop in their role. Staff told us they had supervision meetings. One member of staff told us, "I have had one supervision." Records confirmed that supervision meetings had taken place. However, ten members of staff had only completed one supervision meeting in 2017. There was a supervision matrix in place to record supervision's. The registered manager told us that supervision's were on-going.

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 Act 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Where people were not able to make their own decisions we saw that capacity assessments had been completed to confirm if the person was able to make the specific decision. However, we found that for two people the information in the assessment had been copied and did not relate to the decision that needed to be made. For example, one person had an assessment about their ability to consent to the use of sensor equipment to monitor their movements. The assessment said, 'Visual aids have been used [to help the person to understand the information] by showing them their medication.' The same sentence was recorded in each of the person's capacity assessments. This meant the capacity assessments had not been based on the individual and the specific decision.

DoLS had been requested for people who may have been at risk of being deprived of their liberty. The registered manager showed an understanding of DoLS which was evidenced through the appropriately submitted applications to the local authority. However, we found that all areas where people may have been deprived of their liberty had not been included in the application. For example, one person had motion sensors in place and was not able to consent to the use of these. The use of the sensors had not been identified as a DoLS in the application that had been made to the local authority.

People were not able to tell us if they were asked for consent before staff supported them. One person said, "I think they do." Staff told us they always asked for consent. One member of staff commented, "I always ask if I can help. I ask am I okay to change you?" Observations throughout the day showed some staff consistently asked people for their agreement and consent before supporting them and other staff did not always do this. People told us that they made decisions about aspects of their daily life such as when they went to bed. One person said, "I call them to go to bed when I like." Other people told us that they were not able to make choices such as when they got up. One person said, "Some get up at 5'o clock. There is a lot to get up and they need help." Staff confirmed they had got people up at times that they themselves had not chosen. However this had now improved. One member of staff said, "We were asked to get people up early. We were getting people up at 5am. Now it is 6am if they want to. If they don't want to they don't have to." Staff did understand the need to respect people's choices. One member of staff member told us, "I respect their wishes." Staff had not received specific training in the MCA and showed limited understanding of the principles of this. Staff told us that this was covered under the safeguarding training.

People told us that they sometimes liked the food. One person said, "The food is not bad. It is nothing to shout about." Another person said, "The food is nice. I would like a bigger choice. I don't eat red meat so sometimes there is not a lot." A relative told us, "[Person's name] loves it. She is eating well and has put some weight on."

People were asked to choose from a menu. The menu on display did not reflect the meal on offer during our inspection. People were able to ask for an alternative if they did not want the meal. Where someone had a dietary need such as a soft diet this was not always provided. We saw that people who had been assessed as needing a soft diet were served food that was not suitable for their needs. The cook told us that they had information about people's dietary needs. However, they told us guidance was not in place about what people could eat safely on a soft diet. One cook told us that they had only received training on specialised diets the week before our inspection and had been in post for a number of months. We discussed diabetic diets with both cooks and were told low sugar options such as yoghurt were available and people could have cakes that had been made with sugar if their blood sugars were not too high. This is not in line with

recommended guidance about good practice. One person followed a gluten and dairy free diet. The cook told us that they had run out of some products for this person and were using regular butter as it was dairy free. When checked it was confirmed that butter was not dairy free. The registered manager told us that the person chose to follow this diet and it was not an assessed health need. The registered manager and the cooks told us that the menus were currently being reviewed to make sure they were offering the food people enjoyed. They explained that they were asking people and relatives what they would like.

People were sometimes offered snacks and drinks. This varied depending on the staff on duty. On the first day of our inspection in the Lodge people were offered drinks all day. They were encouraged to drink and jugs of squash were available. However, in the House, people asked for drinks and were told to wait for the drinks trolley. People were given biscuits and drinks. They were not offered a choice. One person asked for lemonade. This was refused as the member of staff did not have it on the drinks trolley. On the second day of our inspection people were offered drinks and snacks throughout the day in both the Lodge and the House.

The dining tables were set with table cloths and different colour plates were used for people who were living with dementia to enable them to differentiate between their plate and table cloth. This follows good practice recommendations from Alzheimer's society. Condiments such as salt and pepper were also available. During lunchtime at the Lodge it was observed that one person tried to put salt in their eye and another attempted to put this into their drink. Staff were available in the dining room to support people. However, staff did not sit with people and assist them to complete their meal. They were regularly disturbed by other people needing support. Where staff did offer encouragement and assistance people responded well to this and ate their meal while staff were with them.

Where people needed their food and fluid intake monitoring this was taking place. However, this was not being completed consistently. Fluid charts appeared to show that people were often having their last drink between 4pm and 5pm. The amount of fluid people were recorded as having was significantly lower than recommended. One person was recommended to have 2000mls per day. They had regularly only been recorded as receiving 1000mls. Staff knew how to identify dehydration and there were no concerns about people being dehydrated. Staff were not correctly recording how much people had to drink.

People were supported to maintain good health and could access health care services when needed. One person told us, "I told them I wanted I saw a doctor and he came." Another person said, "I have seen the doctor and the chiropodist here." A relative confirmed people had access to healthcare. They said, "[Person's name] had a chest infection a month ago. They rang me up early in the morning and got him straight to hospital. By the time they called me the ambulance was pulling up. I was very pleased with their fast response." Staff were aware of people's health needs and told us they reported any changes in people's needs to the senior person on duty who would make appropriate referrals to other professionals if required. Records confirmed that staff supported and referred people promptly.

Requires Improvement

Is the service caring?

Our findings

People told us that most staff were caring. However, we observed a number of times throughout both days of our inspection that staff's approach was not caring. For example, two people requested cold drinks. They were asked to wait for the tea trolley which came 11 minutes later. When this came both times people were given a hot drink that had not been asked for. A member of staff was seen to goad a person into reacting to them. The member of staff appeared please that they had got a reaction. In the House staff spent time observing people. They did not interact with people. During lunchtime at the House we saw a number of interactions that were not caring. For example, staff put aprons on people without asking before doing this. One person informed staff four times during their meal that they could not eat what was on the plate. The person said they could not see. Staff told the person what was on their plate and assisted them to put something on their fork. They then left the person on their own. This happened twice and the person did not eat most of their meal. Staff were standing around the dining room available to assist. One person was in a wheelchair, they were almost laid flat in their chair. The person said they were uncomfortable and asked staff to move them. The staff member responded, "We can't physically pull you up." They did not attempt to assist the person to move to a comfortable position to eat their meal. The person spilt food on their chest while eating and made staff aware of this. Staff did not respond to the person. Twelve minutes later the person said that their bottom hurt. Staff did not respond. The person repeated this six minutes later. Staff assisted the person to leave the room two minutes after this. The registered manager told us they would review the staff's actions and address areas where the approach was not caring through supervisions and team meetings.

In the Lodge, during mealtimes people were not offered the assistance that they needed. Where staff did support people this was done kindly and there were some nice interactions. However, we also saw one person presented behaviour that presented a risk to themselves and others. When they did this the person was left. We observed that the person was left on the floor in the dining room on two occasions and in the lounge on three occasions. A relative told us, "[Senior on duty] went out for a cigarette one day leaving [person's name] on the floor. That is not what you expect." The registered manager agreed they would review how to support the person during these times.

People were sometimes treated with dignity and respect. One person told us, "They are friendly but respectful." A relative commented, "I get the feeling that staff respect the residents. They always close the toilet door when [person's name] is in there." However, one person's privacy and dignity was not protected when they chose to lie on the floor. The person preferred to wear skirts. They were not covered or offered privacy screens even when they were in communal areas in full view of people, and visitors to the home. We also saw that staff called across to other staff in the dining room to explain that they were taking [person's name] to the toilet. This did not protect their privacy.

These matters constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dignity and respect.

People and their relatives were generally positive about the support that they received. One person said,

"They are brilliant. You can't fault them." Another person commented, "Some are very good. Some not so good. Some are rubbish." A relative told us, "The staff have been brilliant. Some of them have left. They are pushed and doing their best." Another relative said, "The carers are amazing; the ones that are left are fantastic." Staff we spoke with demonstrated their commitment to improve the welfare and wellbeing of people that used the service. One staff member said, "My first priority is the residents. I feel sad at the moment. It feels like we are not good enough. It is all about the residents." Some staff did take the time to talk to people, and share jokes with them. Staff did sometime try to respond to people's requests for help. One person said, "We are well looked after. I said I would just love a banana and the next morning there it one on my plate."

People were involved in making some decisions about their care. One person said, "I am asked what I want to wear." This included decisions about meals, going out, and attending activities. Staff explained that they offered people choices about their care. One staff member said, "If someone wants a female carer instead of a male that is their choice."

People's preferences and wishes were taken into account in how their care was delivered by permanent staff. However, relatives told us that newer staff and agency staff did not know how to follow people's routines. One relative said, "We had agreed that it was best for [person's name] to not sit with others during mealtimes as they were happier on their own. Now they are sat with others and they do not eat as well." Another relative told us, "[Person's name] has a very strict routine. The staff have to know it. The new staff have to learn it and that takes time. If something is done differently it creates a ripple effect. You see people becoming anxious." Routines about how people wanted to receive their care were recorded in care plans. A member of staff told us, "Some agency staff don't like to follow the routines. I would prefer to do it myself. I was on with two agency staff last week. That makes it harder."

Staff who worked at the service regularly were knowledgeable about the people who they supported. A relative said, "They seem to know people. They know if they can have a laugh and a joke." Staff could tell us about people's histories and preferences. Staff prompted agency staff to do things in ways that people liked. Information about what was important to the person, their history and what they liked had been provided by the person and their family. This was used to offer people activities that they liked and to have conversations with people about things that mattered to them.

People's visitors were made welcome and were free to see them as they wished. A relative told us, "I can visit whenever. I am here most days." Another relative said, "The staff make me feel very welcome." We saw that people were requested to avoid visits at mealtimes where possible to allow staff to focus their attention and support on people who needed this. This was based on research that this was beneficial to people who used the service.

People's sensitive information was kept secure to protect their right to privacy. The provider had a policy on confidentiality that was followed. For example, we saw people's care records were locked away in secure cabinets when not in use. This meant that people could be confident that their private information was handled safely.

The provider had made improvements to the building since our last inspection. They had introduced signs that guided and orientated people around the building. People had names on their bedroom doors to give them a prompt that this was their personal space. This follows good practice recommendations from Alzheimer's society.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us they were offered activities. However, they also told us the activities co-ordinator was not always available. One person said, "There is nothing today because she is in the canteen." Another person said, "I join in here when there is something on." A relative told us, "They do armchair exercises and that sort of thing." Another relative commented, "They have a chap come round every now and again with an electric organ." Staff told us the activities co-ordinator in the House often provided cover in the kitchen which they were until after lunch. The activities co-ordinator in the Lodge put on a DVD about a coronation that people enjoyed watching. There was conversation's about people's memories of the time and people joined in with singing. Other people were prompted to read magazines about things they were interested in. The activities co-ordinator also provided support at lunch time and an arts and craft session. The provider employed two activities co-ordinators so there was one for each building.

In the House there was no planned programme of events available. There was an activities board. However this only had a poster of national days of celebration. There were no planned activities. The activities co-ordinator in the Lodge told us, "I work with people and find out what they want to do." They asked people if they wanted to join in with activities and suggested crafts which people responded well to.

People's care and support needs were assessed prior to them moving to the service. This was to make sure that the staff team could meet people's needs appropriately. Some people told us that they had been involved in their assessment. One person said, "They plan anything I need." A relative told us, "I had an input when [person's name] first moved in." Records showed that people and their relatives had been involved with their assessment, this included providing information about what the person liked, disliked and hobbies that they enjoyed. However, assessments were not always effective at identifying support that people needed. One person displayed behaviour that put themselves and others at risk. This had not been included in their assessment. The registered manager told us the person did not display this behaviour in front of their relatives and was not known by them at the time of admission. Despite the person showing this behaviour regularly an assessment had not been completed to evidence the service could meet their needs.

People's care plans included information which guided staff on the support they required. Care plans had been developed from their assessments for staff to follow to ensure that their needs were met. Care plans contained information about people's preferences and usual routines. This included information about what was important to each person, their health and details of their life history. However, when people moved to the service on a shorter term stay they had a very limited care plan that did not identify their needs in detail or how to meet these. One person had been at the service for a period of two months. They did not have a detailed care plan in place to tell staff how to provide their support. Care plans did not include all important information. For example, one person had a diet notification form which said they needed to have a fortified diet. A fortified diet is used to help people to maintain and gain weight when they are at risk of malnutrition. This was not included in their care plan.

People were not sure that they had participated in reviewing their care plans. Relatives gave mixed feedback. A relative said, "We asked about a review date and were told not as far as [person's name] knows."

Another relative told us, "There is no date for review." However, One relative said, "[Registered manager] sat down with us and went through the whole care plan. It was the first time." Care plans had been reviewed monthly. They had not always been reviewed in response to incidents to make sure that people's needs had not changed.

People told us that they would speak with staff or the registered manager if they were worried or had any concerns. One person said, "I would get in touch with the staff or go straight to the boss." A relative told us, "We have raised concerns. They had a relative's meeting. It was awful. They are not listening." There were procedures for making compliments and complaints about the service and these were displayed so people and their relatives had access to them. We reviewed details of complaints received and saw action had been taken to address and respond to these within the agreed timescales identified in the policy. Some complaints were on-going at the time of inspection. However these were still within the agreed timescales in the policy.

Handover between staff at the start of each shift ensured important information was shared, acted upon where necessary and recorded. This ensured people's progress was monitored and any follow up actions were recorded.

Inadequate

Is the service well-led?

Our findings

People's relatives told us that they were previously happy with the service that they received. However, they felt that the service provided more recently had not been as good and this had impacted on the care people received. A relative said, "The last month things have changed. Staff have left. Something has gone wrong. The morale is so different. It is sad. Another relative told us, "We had no concerns until recently. It is a shame. We walk away and are worried. We would have recommended the service up until three weeks ago."

The provider had systems and processes in place to identify and assess risks to the health, safety and welfare of people who used the service. However, we found that risks to people were not always identified, assessed or measures put in place to reduce the likelihood of these reoccurring. Assessments that were in place had been reviewed monthly. They had not been reviewed following incidents related to the identified risk to see if any changes were needed. Measures in place to protect people and to reduce risk were not consistently being followed. This was not identified or followed up by the registered manger. Incidents that required further investigation were not always reported correctly. These had been recorded in daily notes. They had not been entered onto the provider's system for logging incidents. Despite there being a number of staff changes and high agency use there were no checks completed to ensure all staff were recording information correctly. This would have enabled the registered manager to be confident that they knew about all incidents that they needed to be aware of and appropriate actions had taken place.

There were systems in place to regularly monitor the quality and safety of the service being provided. These included reviews of care plans which took place monthly. There were a number of discrepancies in the care plans. These had not been identified by the systems in place. Where a person's needs had changed this had been recorded as part of the review notes. However the care plan had not been updated to reflect the person's current needs.

Risks to the health and safety of people using the service had been identified and reported internally. These had not been resolved in a timely fashion or reported to external agencies. One relative told us, "There is only one machine. The water heater is not working in the kitchen, the boiler has been condemned. Why can't the laundry be replaced?" During our inspection we found that the water heater and boiler had been repaired. There was a new washing machine meaning there were two machines available for all 44 people using the service. Works had been identified and the washing machine had been replaced within three weeks. However during the time it was not working there had been a backlog of washing. During our inspection there was a considerable amount of washing that had not been completed and some items had been waiting three days to be washed. People who lived in the Lodge had to wait to have a shower or bath after the boiler had broken. We received this information anonymously. We contacted the service and were told the boiler had been broken for seven to 10 days but had been fixed. This was not reported to the local authority or CQC. It is important events that impact on the service provided and how this runs are reported to external bodies to provide oversight and safeguards for people.

People who were at risk of dehydration had charts in place to monitor their fluid intake. The charts had not been completed correctly. These were not monitored to ensure that people were receiving the correct

amount of fluid. The charts had not been totalled at the end of the day to review how much the person had drunk. They also regularly showed people receiving less than the required amount and having their last drink between 4pm and 5pm. These concerns had not been identified or rectified by the provider.

Staffing levels had been assessed based on the needs of people who used the service. However, as people's needs had not been fully identified or assessed staffing levels were not suitable to meet the needs of people using the service. People, staff and relatives gave mixed feedback about the staffing levels with most feedback being that there were not enough staff. Our observations showed people waiting for support, being left in the middle of tasks so staff could support others and doing things without staff support when they had been assessed as needing this.

These matters constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

The provider had failed to submit statutory notifications in relation to incidents that they have a duty to report to CQC by law. For example, allegations of abuse. The provider did not notify us of one incident of a person kicking another or a person threatening to kill another. They did not notify us of two serious injuries to people. One of these incidents was a potential broken nose and the other a head injury. The provider did not notify us that the boiler had broken leaving parts of the service without water which is an event that stopped the service running normally. These notifications are an important safeguard for people using the service. Failure to notify CQC denies people an important level of oversight and protection.

These matters constituted a breach of the Care Quality Commission (Registration) Regulations 2009: Regulation 18: Notification of other incidents.

Relatives gave us mixed feedback about feeling able to approach the registered manager. One relative said, "The manager is [registered manager]. You don't see her
very often." Another relative told us, "[Registered manager] is very approachable." One relative commented, "[Registered manager] is naturally caring. They are not listening at the moment. You cannot go to the [regional manager]. The only option is head office." Staff gave us mixed feedback about feeling supported in their role. One staff member said, "I feel supported in my role." Another staff member told us, "The manager is very approachable. Anything you need you get." One member of staff commented, "I cannot go [registered manager]. They do not listen and nothing changes." The registered manager told us they worked shifts at the service to keep up their understanding of people's needs and also to work with the staff so they felt supported. They told us they were available if anyone wanted to talk to them. Staff meetings had taken place every three months. Minutes from these showed staff had the opportunity to discuss any concerns they had, training, health and safety and good practice.

People told us they had some opportunities to give feedback to the provider. One person said, "I did a questionnaire some years ago." People told us that they had not been asked to attend meetings until recently. Minutes from meetings that had been held with residents and relatives showed that meetings had been held six monthly. People were asked for their feedback on the service, menus and activities. A relative commented, "We had a meeting the other day due to an issue that had been in the press. They have said they will have them monthly now; which will be a big help." Another relative told us, "I found out about the meeting while I was having my dinner and was late getting there. We were not given warning. There was little point in the meeting as they were not willing to listen to our concerns." Other relatives confirmed they were given very little notice of the meeting. One said, "I received the letter in the post at 4pm. It was due to start at 6pm. I couldn't make it." The regional manager told us they had offered relatives one to one meetings following the relatives meeting to discuss their concerns individually. A survey had been sent out in April

2017 to people who used the service and their relatives. The feedback was generally positive. We saw the results were displayed in the service. In both buildings there was an electronic tablet people could use to provide feedback on the service. A relative told us, "I spent a long time filling this in. When I came to submit it the information would not send. [Registered manager] told me they never received my feedback." Other people told us they had not used this method of feedback. However it was available at all times if anyone wanted to use it.

The registered manager was supported in their role by the regional manager. They could also access the provider's other support networks such as the resident experience team and their in-house pharmacist. During our inspection we met people from these teams who told us they were committed to supporting the registered manager to drive the improvements needed to ensure a quality service for the people who used the service.

The service had up to date operational policies and procedures in place which covered all aspects of service delivery including safeguarding, medication, whistleblowing, recruitment, complaints, equality and diversity. Those which were relevant to staff were also contained in the staff handbook.

The ratings from the previous inspection had been displayed in the service and on the provider's website. The display of ratings is required by us to ensure the provider is open and transparent with people who use the service and their relatives and visitors to the service.

Westroyd Care Home has been inspected three times since June 2015. At all three of these inspections the service was rated as requires improvement in the Well-led section. We have taken this into account when making our judgements at this inspection.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the commission without delay of incidents that occurred during the carrying on of a regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not always treated with dignity and respect.

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 People were not protected from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were not always kept clean and well maintained. The provider did not have suitable arrangements for the service, maintenance and replacement of equipment.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had not deployed sufficient numbers of staff to meet people's care and treatment needs.

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 Care and treatment was not provided in a safe way for people. Risk assessments were not always completed where there was a risk to the health safety and welfare of people using the services. The provider had not done all that was reasonably practicable to mitigate risks. Relevant health and safety concerns were not included in people's care plans.

The enforcement action we took:

We issued a warning notice. We required the provider to be compliant with the regulation by 30 September 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to ensure that the provider met the regulations. The provider was not able to identify and assess risks to the health, safety and / or welfare of people who used the service. Processes were not used effectively to minimise the likelihood of risks. Risks had not been escalated within the organisation or to a relevant external body.

The enforcement action we took:

We issued a warning notice. We required the provider to be meet the regulation by 30 September 2017.