Three Arches Care Ltd

Westhorpe Hall

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Westhorpe Hall is a residential care home providing personal care to eight people at the time of our inspection. Some of those people were living with dementia. The service can support up to 21 people. The service is in a listed building with enclosed gardens. It is located in a rural area and people would require support to access the local community.

People's experience of using this service and what we found
Risks were not always assessed or effectively managed to keep people safe. Staff were not provided with clear guidance on how risks such as those associated with people's health should be managed. Documentation was not always fully completed, and we could not be assured that people were receiving care and support in line with best practice.

Incidents were not always identified, escalated or collated to ensure provider oversight and learning to reduce the risks to people.

Safety checks were not robust to ensure the safety of the premises. We found gaps in the provider oversight of fire safety and legionella.

The service had experienced a high turnover of staff and challenges recruiting staff. As a result, there was a significant use of agency staff. This had been compounded by a recent COVID 19 outbreak and the contingency plans in place for ensuring there were enough staff on duty were not robust.

There were processes in place to check on the suitability of staff prior to them starting work at the service. However, the checks and induction provided to agency staff needed improvement.

Medicines were not always managed in line with professional guidance. Competency assessments for staff were not always in place and topical medicines were not stored securely which placed people at risk of harm.

Safeguarding concerns were not always escalated, and staff were not clear about the actions they should take, where there was a concern.

There were systems in place to manage infection control, but the home's policy had not been updated since the start of the pandemic. Improvements were needed in areas such as the storage of personal protective equipment (PPE) and auditing. We have signposted the provider to resources to develop their approach. The provider was following the government's guidance on whole home testing for people and staff. This included rapid testing and weekly testing. Visits by relatives had been facilitated by the service.

The service was not managed effectively and had not had a stable leadership team for some time. Staff

morale was low. A new manager started work at the service during the inspection. Audits on quality and safety had not been consistently completed and those in place had not identified the shortfalls we found in areas such as medicines, care planning and safety.

Rating at last inspection
The last rating for this service was Good (published 8 July 2021).

Why we inspected
This inspection was prompted by a review of the information we held about this service. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

We received concerns in relation to medicines and the delivery of care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report. For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards

of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Westhorpe Hall

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by an inspector, a medicines 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 by Experience spoke with people's relatives over the telephone.

Service and service type
Westhorpe Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
The service did not have a manager registered with the Care Quality Commission. Registered managers and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.
Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we

inspected the service and made the judgements in this report.

During the inspection
We spoke with two people who lived in the service and six relatives about their experience of the care provided. We also spoke with six members of staff and members of the management team.

We observed people's care to help us understand the experience of people who could not talk with us. We reviewed a range of records. This included three people's care records and medication records. We looked at a variety of records relating to the management of the service, staff recruitment records and quality assurance records.

After the inspection
We continued to seek clarification from the provider's representative to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question as Good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Risks to people's safety had not always been identified and actions taken to mitigate the risk. Moving and handling plans were not always clear, and information was stored in different places increasing the risk of staff confusion and error. One person's records stated staff should assist the person to move by holding on to the waist band of their trousers, which is not recognised safe practice.
• There were a number of recognised risk assessment tools in place such as Waterlow and Malnutrition Universal Screening Tool (MUST). These are tools to assess the risk of pressure areas developing and malnourishment. Waterlow scorings were not always accurately completed, and we were not assured the information was accurate or would highlight actual deterioration in people's wellbeing.
• The service supported a number of people with diabetes. Guidance was not always available in people's care plans as to the signs or symptoms of high or low blood sugar levels and the actions staff should take to keep people safe.
• Staff provided an account of the actions they would take to support a person following a fall, which included seeking medical input and documenting what happened in the communication book. However, staff did not always complete incident reports and near misses were not identified or recorded as a near miss. Therefore, there was no collation of data on incidents or meaningful review of what happened. It was not clear what steps were being taken to mitigate further incidents.
• Topical medicines located in people's bedrooms were not secured placing people at risk of harm. One person was found with another person's prescribed cream which they described as their toothpaste and if ingested would have caused them harm. Staff had highlighted the risk, but adequate actions had not been taken as prescribed creams continued to be accessible to people.
• Checks were undertaken on the safety of the environment and equipment, however there were gaps in the recording and we were not assured issues were always addressed in a proactive way. Moving and handling equipment had not been serviced as per the recommended guidelines. The provider told us this delay was due to COVID 19 and this was actioned during the inspection.
• The fire service had previously identified shortfalls in the systems in place to protect people in the event of a fire. The provider's fire safety risk assessment had recently been reviewed and an action plan was in place, but we could not see areas had always been addressed in line with the recommendations.
• Doors were held open with bean bags and the recommendations that they should be fitted with self-closing devices had not been actioned. We noted damage to the seals on doors and while some had been repaired others had not. The holding open of doors and poor door seals poses risks in the event of a fire as they would prevent the doors closing.
• Certificates were in place to show that water had been tested for legionella bacteria, but we were not assured other checks such on infrequently used outlets were taking place as recommended in the risk assessment.

These shortfalls put people at risk and are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● The provider's infection prevention and control policy was not adequately detailed or reflected the pandemic or national guidance. It did not provide adequate guidance to staff on the risks associated with COVID 19. We were subsequently provided with a new and updated policy, which we were assured would be cascaded to staff.

● We were not fully assured that the provider was storing Personal Protective Equipment (PPE) effectively and safely. We observed PPE being stored on the floor outside a bedroom of a person who was isolating, which increased the risk of cross infection.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Furnishings and equipment were tired and, in some cases, damaged which made cleaning difficult. Some liquid soap dispensers and pedal bins were broken.

● Staff told us they had received infection control training, but we observed they did not always follow best practice. We observed staff offering biscuits to people from a tin. One person touched the biscuits with their hands and lifted some out before returning them. These biscuits were subsequently offered to other people and visitors.

The shortfalls in infection control put people at risk and are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
We have signposted the provider to resources to develop their approach.

Visiting in care homes

● We observed the provider was facilitating visits to the service and people were supported to maintain contacts with their friends and relatives.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

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

Staffing and recruitment

• The service had experienced a high turnover of staff and challenges recruiting staff. As a result, there was significant use of agency staff. This had been compounded by a recent COVID 19 outbreak, but the contingency plans in place for ensuring there were enough care staff on duty were not robust.

• Five people were assessed as requiring two staff to mobilise. There was an occasion when there were only two care staff on duty which was insufficient and placed people at risk of poor care.

• There had been a recent night shift where the service had been staffed entirely by agency staff. Gaps in records and care planning meant that clear documentation was not always in place to guide agency staff.

There was no robust system for the checking of agency staff on arrival and the provision of a formalised induction into the safety systems within the service. These staffing arrangements were not robust and placed people at risk of harm.
• At weekends there was no onsite management presence and the home operated with three care staff. There was no system of senior staff and it was unclear who was leading the shift. The provider told us they intended to appoint senior staff who would be on duty and provide leadership.
• Staff told us the on-call arrangements were not effective, and managers did not always answer their telephone. The newly appointed director told us it was acknowledged there had been problems in the past but assured us the current arrangements were working better.
• There were enough care staff on duty on the day of our site visit and staff were visible. We observed staff responding to people's needs in a timely way. There were no housekeeping staff, but the activity member of staff undertook these duties in their absence. This took them away from providing activity to people using the service.
• Relatives told us there was generally enough staff on duty but expressed concerns that there was not always staff in the communal areas when they visited. We received mixed feedback on the skills of staff, some relatives spoke highly of staff, but others were less positive.

These shortfalls in staffing put people at risk and are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Recruitment checks had been completed before new staff commenced employment. However, the arrangements for checking the identity and qualifications of agency staff as outlined previously, needed improvement.

Systems and processes to safeguard people from the risk of abuse
• People were not being kept safe as incidents were not being collated and consistently reported to the Local Authority or CQC.
• We identified an incident where a person had been involved in an altercation which resulted in treatment by health professionals. This had not been reported to safeguarding as required.
• This meant opportunities to learn lessons and improve practice were missed. Following the inspection, we made a referral to the local safeguarding authority in relation to the risks to people that we found.
• People and their relatives were inconsistent in their feedback about the service. One described the staff as, "Mature and compassionate," but others said they would not recommend the service to others.
• Staff had received safeguarding training and told us they would escalate concerns to senior staff but were less clear about the role of the Local Authority in investigating concerns.

Using medicines safely
• Records showed overall that people were receiving their medicines as prescribed and staff carried out regular checks of people's medicines.
• Oral medicines were stored securely and at appropriate temperatures. There was written information available for staff about people's medicines, however, there were some inconsistencies in the information, and some had not been reviewed recently. There was also a lack of information for staff about the application of people's topical medicines.
• When people were given medicines prescribed to be given on a discretionary basis when required there was most often a lack of records completed about why the medicines were needed when used.
• For some members of staff handling and administering people's medicines there was a lack of records confirming they had recently had their competency checked. Therefore, we could not be assured people had been given their medicines by staff that were sufficiently skilled and competent.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

• The service was not managed effectively and did not have a stable leadership team. At our previous inspection we found there had been a high turnover of managers which had been disruptive. At this inspection we found improvements had not been made. The service did not have registered manager and two previous managers had left after a short period in post. The regional manager had also recently left, and the deputy manager left during the inspection.
• The new director of residential care facilitated this inspection and a new manager started to work at the service in the week following our site visit. We were not however assured there was continuity of leadership for people and staff.
• Systems and processes to assess, monitor and mitigate risks were ineffective. Records including care plans lacked detail and did not provide staff with clear guidance. We could not see that people were receiving regular baths and documentation such as repositioning charts were not consistently completed and did not evidence that people were receiving the care they needed.
• Incidents and near misses were not always identified and escalated appropriately which meant steps were not always taken to prevent a similar issue occurring.
• There were some audits on quality and safety, but they had not been consistently undertaken and did not demonstrate effective monitoring. There was no training matrix to identify gaps in staff training and audits had failed to identify the issues we found in relation to risks to people, care plans and guidance.
• There was a low level of staff satisfaction and staff did not feel supported or appreciated. The systems in place to support staff were not effective and care staff described how after office hours they struggled to get hold of a manager as the on-call staff did not answer their telephone.
• A staff survey had been undertaken and some of these issues had been identified but there was no action plan in place to address the areas highlighted.

The shortfalls were identified were a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the site visit we received an action plan from the director to assure us they were taking the

concerns seriously. We saw that they had been open with the Local Authority about the concerns and the immediate steps they were taking to mitigate risks.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others; Continuous learning and improving care

• The service had relationships with the Local Authority and health professionals. We saw they contacted professionals for advice but did not always clearly document what they were told which increased the risk that advice may not be implemented.

• People told us they were happy at the service. Relatives told us they had been kept informed about changes to their relative's wellbeing and the service had been facilitating visits in line with the recommended guidance. Relatives were however unclear about the management arrangements and had not always been involved in the care planning for their relative.

• Morale among staff was low. Staff spoke warmly about the people living in the service and told us they tried their best to provide good care. However, some staff reported that they did not always work as a team and the senior management team did not listen to them when they reported concerns.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's safety had not always been identified and appropriate actions taken to mitigate the risk

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess, monitor and improve quality and safety were not working effectively

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The deployment of staff was not effective and did not provide people with the support they needed