Nursing Homes Services Limited

Westacre Nursing Home

Inspection report

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13 February 2018
14 February 2018
06 March 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an urgent unannounced inspection of this home on 13, 14 February and 6 March 2018. Before the inspection we had received nine whistleblowing concerns about unsafe practices at the home which were allegedly putting people at very high risk of harm. At this inspection we found serious concerns about the safety and welfare of people.

The registered provider had failed to; identify the risks associated with people's care needs, ensure people were safeguarded from harm by sufficient staff who understood how to meet their needs; ensure people consented to their care and were not unlawfully deprived of their liberty; provide person centred care in line with people's needs and preferences; ensure people were treated with dignity and respect at all times; respond to complaints in a timely and effective manner; provide effective leadership and overall management of the home.

The registered provider had failed to be compliant with all of the fundamental standards set out by law. You will find further information on the breaches of regulation we found in the full version of the report.

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

The service 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 will 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 home provides accommodation and personal care for up to 55 older people, some of whom live with mental health problems or dementia. Accommodation is arranged over two floors with stair and lift access

to all areas. At the time of our inspection 43 people lived at the home.

At the time of our inspection a new registered manager had been in post since January 2018. The previous registered manager remained working in the home but in the role of clinical manager. The clinical manager left the home on the second day of our inspection. 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.

On the first day of our inspection a new general manager had been in post for two weeks and told us they were planning to become the registered manager for the home. The current registered manager was planning to deregister and return to their previous role of finance manager. During our inspection we found there was a serious lack of guidance and leadership in the home to ensure all staff had a good understanding of their roles and responsibilities in maintaining the safety and welfare of people who lived in the home.

Whilst there were safe recruitment practices in the home, there were not sufficient staff with suitable skills, knowledge and experience deployed in the home to meet the needs of people.

Risk assessments had not always been completed to support staff in mitigating the risks associated with people's care. Care records were not always available, accurate and lacked up to date information to ensure staff had information on how to meet people's needs. This was of particular importance with the high use of agency staff in the home.

Whilst systems were in place to support staff in recognising signs of abuse, they had not identified any concerns about the safety and welfare of people in the home as we found during our inspection. There were a number of incidents of alleged abuse in the home during our inspection and we had received a high number of concerns before our inspection. These concerns were substantiated during our inspection and had not been raised in line with the registered providers policies and procedures to safeguard people.

People were not always valued and respected as individuals. Staff did not always know people well and could not always demonstrate how to meet people's individualised needs. Whilst some care staff cared for people in a kind and empathetic way, we observed some very poor practices which did not always show respect and dignity for people. These practices were not challenged by other staff or the registered provider. The training staff had received was not always reflected in the care some staff provided.

People did not always receive care which was person centred and individual to their specific needs. There was a lack of meaningful activities and interactions in the home to reduce the risk of social isolation for people.

Where people could not consent to their care, staff had not sought appropriate guidance and followed legislation designed to protect people's rights and freedom.

Whilst there was a system in place to allow people to express any concerns or complaints they may have, these were not managed effectively. There was a lack of robust and effective audit in the home to monitor and review the quality and effectiveness of the service provided at the home.

Whilst people received foods in line with their preferences and choices, they did not always have a good dining experience.

The home was clean and maintenance was completed in a timely way.
We provided feedback of our findings following the inspection to the owners of Westacre Nursing Home (and registered providers), the nominated individual for the registered provider and another senior manager for the home. We requested immediate action be taken. In addition, we referred the concerns we found to the local authority responsible for safeguarding.

We found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We also found one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

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.

There were not always sufficient staff with appropriate skills and knowledge deployed to meet people's needs and ensure their safety and welfare.

Risks associated with people's care had not always been identified and assessments made to reduce these risks for people.

Systems which were in place to recognise and report allegations of abuse were not used effectively to ensure the safety and welfare of people.

Some improvements were required in the management of people's medicines.

The home was clean and maintenance was completed in a timely way.

Staff recruited to the home had been assessed as to their suitability to work with people.

Is the service effective?

Inadequate

The service was not effective.

Where people could not consent to their care, staff had not always sought appropriate guidance and followed legislation designed to protect people's rights and freedom. We found evidence some people had been restrained unlawfully.

Not all staff had received up to date training to be able to deliver care in line with people's needs. Where training was up to date we were not assured the registered provider and registered manager had taken steps to ensure the practices were followed and embedded.

Staff did not always know people well and could not always demonstrate how to meet their individual needs.

People did not always enjoy a good dining experience.

Is the service caring?

Inadequate

The service was not caring.

People said staff were mostly caring and supportive of their needs. However we found people were not always valued and respected as individuals.

Staff did not always know people well. Whilst some care staff cared for people in a kind and empathetic way, we observed some very poor practices which did not always show respect and dignity for people. These practices were not challenged by other staff.

People and their relatives were not involved in their care planning.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive care which was person centred and individual to their specific needs.

There was a lack of meaningful activities and interactions in the home to reduce the risk of social isolation for people.

Complaints made in the home had not been addressed in line with the registered provider's policies and procedures.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of leadership and organisation in the management of the home. Staff did not have a good understanding of their roles and responsibilities. There was a very poor culture evident within the home of staff led care rather than person centred care.

Care records were poor and lacked up to date information.

Whilst the registered provider had systems in place to monitor and review the quality and effectiveness of the service provided at the home, these had not been used effectively. Audits in place had not identified the concerns we noted at our inspection.

Westacre Nursing 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.

On 13 February 2018 two inspectors and an expert by experience attended this urgent unannounced inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the 14 February and 6 March 2018 two inspectors completed the inspection.

Before our inspection we reviewed the information we held about the home, including previous inspection reports and nine separate whistleblowing concerns which had been sent to CQC since 9 January 2018. We received a further whistleblowing concern following on 17 February 2018. We reviewed notifications of incidents and events which had occurred in the home since our last inspection. A notification is information about important events which the service is required to send us by law.

We spoke with six people and two relatives to gain their views of the home. Many people who lived at the home were not able to talk with us about the care they received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to understand the experience of people who could not talk with us. We observed care and support being delivered by staff and their interactions with people in communal areas of the home.

We spoke with the registered manager, a general manager, the clinical manager, three registered nurses and one care assistant. We also spoke with the activities coordinator, the cook and a member of the maintenance staff.

We looked at the care plans and associated records for eleven people and the medicine administration records for 12 people. We looked at a range of records relating to the management of the service including records of; accidents and incidents, quality assurance documents, five staff recruitment files, complaints, policies and procedures.

We spoke with a health care professional and following our visit we liaised with the local authority and local commissioning groups to provide feedback on our findings and gain their views on the service.

Inadequate

Is the service safe?

Our findings

People and their relatives generally felt the home was safe. One person said, "Yes. The security is good." However, they also told us, "The only upsetting thing is when some of the people fall around and get upset." Another person told us, "It's okay, the staff are here to help us." A relative told us, "The team look after [person] but when it's agency [staff] it can go a bit awry." Staff told us they felt people were safe in the home. One member of staff told us, "Yes, they are. We [staff] have to go the extra mile because it's so busy, but they are." A second member of staff told us, ""I'm aware that there have been problems here but I do think there's been improvement. There's better manual handling, using proper techniques, enforced a lot more. There's a general smoothness with more staff on duty. We get more help with lunches. I don't think anyone is at risk here". However, staff recognised a high number of agency staff working in the home meant that there was not always enough staff with a good understanding of people's needs available in the home.

We had received whistleblowing concerns which identified there were not always sufficient staff available to meet the needs of people. Whilst staff rotas showed there were consistent numbers of staff deployed to meet people's needs, the suitability and experience of staff working in the home was not sufficient to meet the needs of people. There was a high use of external agency staff working in the home and staff did not always demonstrate the skills and knowledge to provide safe and effective care to meet the needs of people.

On one day of our inspection we observed an agency member of staff working alone on several occasions even though it was their first day working in the home. They were clearly unprepared to be working alone as they had to keep asking staff for assistance. We noted that, on the first two days of our inspection, call and alarm bells were ringing incessantly throughout the morning. Staff were evidently very busy, working hurriedly around the home. Staff did not have time to interact with people in a meaningful way. They worked in a task orientated way to complete tasks according to the routine of the day. On the third day of our inspection we saw there were more staff available however there was a lack of senior staff working with staff to ensure people received care which was safe and in line with their needs. Care remained task orientated.

We asked a staff member if the first day of our inspection was a normal day for them. One staff member told us, "It's the busiest I've known. Normally, we have them [people] done by twelve o'clock but when we run later, like today it's later when we get to some people and they might be soaking. That puts us back even further. We have a lot of agency staff too. Some of them are experienced regulars but we had one and it was their second day in care. They didn't know how to handle people, to feed them and had had no training". Another member of staff said, "A few months ago, the way we work was changed. The activity coordinators were told they couldn't do certain things which made things more difficult. That and the fact we took on more serious and complex residents recently. One person was admitted without a pre-admission assessment and ended up in hospital. We spoke with the owners about this and they said we should be able to manage". A relative told us, "No, [there is not enough staff], not at the moment because there are a lot of agency staff so things take longer and the communication is difficult."

A third member of staff we spoke with told us one of the reasons the day staff were so busy on this day was because night staff, "Usually helped them by getting some people up," but hadn't on this occasion. This clearly demonstrated a task orientated and staff focused delivery of care for people. We did not see any evidence of people being got up against their will during our visit, which began at 06.30am on the first day. We spoke with the general manager about this. They confirmed that night staff did give personal care to some people before 08:00am, but only if they wanted it. Night staff confirmed this. A member of staff told us the night staff had stopped doing this 'in protest' at having staffing numbers reduced. The registered manager told us care staff numbers had been reduced by one but this was because an extra registered nurse had been recruited due to concerns raised by night nursing staff.

There was not always sufficient staff available to meet people's needs when they were required. At one lunchtime we saw four members of staff were available in a communal lounge and dining area to support 20 people with their meals, most of whom needed some assistance if not full assistance with their meal. They provided support for people in a task orientated way and people had to wait to have their meal as there were not enough staff to support them. This practice was evident throughout our inspection.
Lunch was first served at 12:30pm. Staff started to support one person to eat their meal in a lounge area an hour after others had completed their meal. This meant people were sitting watching others eat their meals whilst they waited for theirs. Other people who were supported to eat their meals in their room were still being assisted at 13:45pm. For another person who was unable to mobilise without staff support, we saw they were left unassisted in a wheelchair for over six minutes by a member of staff who went to find another member of staff to assist them in supporting this person. They did not return to the person who attempted to get out of their wheelchair twice before two other members of staff saw them and assisted them to move.

The registered provider and registered manager had failed to ensure there were sufficient numbers of suitably skilled and experienced staff deployed at all times. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On 16 February 2018 the registered provider sent information to the Commission of immediate actions they were taking to ensure there were sufficient staff available to meet the needs of people. A dependency tool had been used to assess each person's individual needs and identify the number of staff required to meet the needs of all the people who lived at Westacre Nursing Home. Additional staff had been employed through an external agency. On 6 March 2018 we saw that whilst there were increased numbers of staff available, there was a lack of senior staff monitoring the care being provided for people to ensure their safety and welfare.

Before the inspection we had received whistleblowing concerns which identified the risks associated with people's care had not always been identified and sufficient actions taken to reduce these risks. During the inspection we found risks associated with people's care needs had not always been identified and appropriate plans of care were not in place to mitigate these risks.

For those people who lived with dementia or mental health problems, we found records which showed they could display behaviours which may cause them or others harms and/or distress. The risks associated with this had not been assessed, triggers to these behaviours had not been identified and no management plans were in place to ensure people did not come to harm if these behaviours were displayed.

For example, we observed one person who could become very agitated and aggressive when they were supported by staff to receive personal care. We saw this person was very distressed following interactions from staff during personal care and had received an injury to their arm. There were no records in place to identify the risks associated with this person's behaviours or staff interactions with them. We were not

assured the risks associated with providing support for this person had been assessed to ensure their safety and welfare or that of staff.

Risks associated with nutrition and weight loss were monitored but appropriate actions had not always been taken to address any concerns identified in a timely manner. For one person we saw they had lost 4.1kg of weight, which was nearly 10% of their body weight, between October and December 2017. They had been assessed in October 2017 as being at high risk of malnutrition however they had not been weighed since December 2017 and no actions had been taken to identify the cause of this weight loss or address it. We were not assured the risk associated with poor nutrition and weight loss had been addressed to ensure the safety and welfare of this person.

For people who were at risk of falls there was a lack of clear information and assessment of these risks for staff to follow. There had been a high incidence of falls in the home. Whilst the incidents of falls in the home were recorded, the registered provider had failed to note patterns or themes from these events and take appropriate action to address these. For example, one person had fallen eight times in three weeks. There were no risk assessments in place for this person to show staff how to mitigate this risk or the risk of harm if they did fall. We were not assured people's safety and welfare were reviewed in line with the high risk of them falling.

The risks associated with people's care had not always been identified and actions taken to mitigate these. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

On 16 February 2018 the registered provider sent information to the Commission of immediate actions they were taking to ensure the safety and welfare of people. When we carried out a further day of inspection on 6 March 2018 we found these actions had not all been completed. Following our inspection the registered provider identified how they would work closely with the local authority and commissioning groups to ensure the safety and welfare prioritise actions in the home to be compliant with all of the fundamental standards set out by law.
Before the inspection we had received whistleblowing concerns which identified staff did not follow safeguarding policies and procedures which were in place in the home to ensure the safety and welfare of people. We found that, whilst the appropriate policies and procedures were in place staff did not always follow these. People were not always protected from abuse, neglect or harassment. Training records showed 21 of 31 members of registered nursing and care staff working in the home had not received up to date training on the safeguarding of people and how to recognise abuse.

We observed care and support being provided to people which demonstrated task orientated care practices and poor care being provided for people which could constitute neglect. Staff did not identify this as potential abuse. Concerns were raised during the second day of our inspection by a member of staff about the alleged abusive treatment of four people by another member of staff. For example, it was alleged two people had been assisted to wash and dress in a rough and undignified manner by a member of staff and another had been moved from their bed to a chair without the appropriate use of equipment to ensure their safety and welfare. These alleged abusive actions took place while we were inspecting in the home and we made a referral to the local safeguarding authority about this.

We saw similar allegations of abuse had been made in the home. Whilst these allegations of abuse had been investigated by the clinical manager, no actions had been taken to ensure the safety and welfare of people and prevent further abuse.

Incidents of abuse were not always reported to the local authority appropriately. We identified two incidents

between people which should have been reported to the local safeguarding authority as potential abuse; however these had not been highlighted as of concern. The local authority confirmed they were not aware of these.

We saw records which showed incidents of poor staff conduct and alleged abuse had been reported to the previous registered manager, who was working as the clinical lead at the time of the inspection. These had not been dealt with in accordance with the registered provider's safeguarding policies and procedures. Whilst a whistleblowing policy was available for staff to use, the concerns which were raised with CQC had not always been raised in the home by staff who were concerned about the unsafe practices and potential abuse they had witnessed.

Following our inspection we made three safeguarding referrals to the local authority with regard to the poor and unsafe practices we had witnessed in the home. These were under review at the time of our report. The registered provider and registered manager had failed to ensure systems and processes were operated effectively in the home to prevent the abuse of people and robustly investigate concerns immediately. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On 16 February 2018 the registered provider sent information to the Commission of immediate actions they were taking to ensure the safety and welfare of people. This included the immediate suspension of some staff and referrals to the local safeguarding authority and CQC of incidents and events of potential abuse and neglect we had identified, to seek appropriate support and advice for people. On 6 March 2018 we saw the registered provider had taken some actions to report safeguarding matters although further work was required to ensure this practice was maintained in the home.

People received their medicines in a safe and effective way from registered nurses. There was a system of audit and review in place for the administration of regular medicines. Medicines were stored and administered safely. Care records showed one person received their medicines covertly. Covert medicines are those given in a disguised form, for example in food or drink, where a person is refusing treatment due to their mental health condition. The home had ensured relatives and health care professionals had been fully involved in a best interests' decision making process about the administration of these medicines. This was in line with the Mental Capacity Act 2005 to ensure the safety and welfare of the person.

However, for medicines which were prescribed as required (PRN), protocols were not in place to support staff in the safe administration and monitoring of these medicines. For example, for people who required medicines to reduce anxiety or agitation or for the relief of pain, we saw staff did not monitor the use and effectiveness of these medicines. The general manager told us this would be addressed.

Following our inspection we received further whistleblowing concerns about the poor and inappropriate administration of medicines in the home. Whilst these were not witnessed during our inspection, these concerns were referred to the local authority for further review.

The risks associated with moving people in the event of an emergency in the home had been assessed. Personal evacuation plans were in place and readily available in the event of an evacuation of the home although these were not always an accurate reflection of people's needs. The clinical manager told us this matter would be addressed urgently. A robust business continuity plan was in place to ensure people were safe in the event of fire or other utilities breakdown such as a power failure.

The home was clean and well maintained. Electrical, gas, and water checks were completed routinely in the

home to ensure this equipment was safe to use. There were effective systems in place to identify maintenance issues in the home and how or when these were addressed. Equipment in use in the home such as hoists and wheelchairs were well maintained. However, there was not a system in place to ensure clinical equipment such as a suction machine and syringe driver were well maintained and always ready for use. The general manager told us they would address this concern immediately.

There were safe and efficient methods of recruitment in place. Recruitment records included proof of identity, two references and an application form. Disclosure and Barring Service (DBS) checks were in place for all staff. These help employers make safer recruitment decisions to minimise the risk of unsuitable people working with people who use care and support services. Staff did not start work until all recruitment checks had been completed. Recruitment checks and information was available for all agency staff who worked in the home.

Inadequate

Is the service effective?

Our findings

Two people who were able to express their wishes told us they were provided choices in their daily lives including what they wanted to eat and what activities they participated in during the day. One told us how they chose when they wanted to go to bed and when they got up as they were independent. Another told us there was a good choice of food in the home. However, we observed people were not always offered choice and did not always consent to the care they received.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Where people had the mental capacity to make decisions about their care we saw staff respected their wishes and supported them to remain independent. For example, one person chose to leave a busy dining area to eat their meal in their own room. This decision was respected and another person who chose to sit in a quiet area of the home was supported by staff to do this.

However, for people who did not have the capacity to make decisions, or their capacity fluctuated, people did not always receive care to which they had consented and which was in line with their wishes. For example, one person who could become very distressed and agitated when staff supported them with personal care; staff did not respect this person's wishes. The person's capacity to make decisions about their care had not been assessed. We heard this person behind a closed door shouting at staff to, "Stop it, stop him," and, "Please help me, stop." They said, "I don't want this, stop," in a very distressed manner. Staff persisted to support this person for seven minutes whilst they continued to shout in distress and clearly told staff they did not want to receive this care and were not consenting to it. When this person left their room they were visibly distressed and agitated. Staff told us this person did not like to have personal care however there was no information to show best interests decisions had been made to support this person receiving appropriate care. In addition, there was no information to ensure that any personal care was provided in the least restrictive manner and in a way which would cause the person the least distress. We were not assured this person received care and support to which they had consented and was in line with their wishes or in their best interests.

The registered manager told us this matter would be looked into immediately. Following our inspection, we raised a referral to the local safeguarding team about the care this person was receiving. We observed poor practices where staff provided care for people without asking people's consent. For example, at mealtimes, some staff placed napkins around people's necks without asking permission from the person.

For people who lacked the mental capacity to make decisions care records did not always hold information to show when people may require support to make a decision and who should be involved in best interests' decision making for people. For people who had the legal authority to make decisions for their loved ones,

documentation did clearly reflect this, however we were not assured staff were always guided by the principles of the MCA.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards. For 13 people who lived at the home an application had been approved by the local authority with regard to them remaining at the home to receive all care or leaving the home unescorted. A further 24 applications were pending with the local authority or were being submitted at the time of our inspection. We asked one member of staff what the implications of the MCA and the Deprivation of Liberty Safeguards had for the people they were caring for. They were unable to tell us this.

During our inspection we identified several working practices which could constitute restraint of a person which had not been identified in plans of care and people had not consented to. For example, for three people who remained in a wheelchair or suitably adapted recliner chair to receive their care, a lap belt was in place to prevent them slipping from or leaving the chair independently. There was no information available in care records to show these people's capacity to consent to this restraint had been assessed, or that a decision had been made in their best interests to have this restraint in place.

For one person who was able to mobilise independently we saw staff encouraged them to sit with a table in front of them which could not be moved independently. We saw this person was discouraged from mobilising independently whilst this table was in place as they were unable to move it. When they tried to move this they were at very high risk of falling as the table was not on wheels and difficult to move. This restraint was not authorised and is not good practice to support people in remaining independent.

Daily care records clearly identified when one person had been physically aggressive with staff that they had been restrained by a member of staff holding their hands to allow other staff to continue providing their care. Incidents forms reflected this restraining behaviour from staff. There was no follow up information from these incidents to show how staff could manage any restraint a person may need and how to ensure this did not cause harm to people.
Another person who was able to mobilise independently in the home approached a locked door and asked staff if they could go outside. A staff member said, "No you can't get out, it's nearly time for lunch." The member of staff made no attempt to support this person and dismissed their request. People were being restrained by staff that had a poor understanding of the MCA and Deprivation of Liberty Safeguards.

Staff were using practices that were not least restrictive, without clear guidance and without the appropriate legal authority to do so. Failure to ensure people were not unlawfully deprived of their liberty was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked to speak with staff about the training, supervision and appraisals they had received, however we were told staff did not have time to speak with us as they were busy. From staff personal records we saw supervision sessions were held with them. However, we were not assured, from the practices and lack of reporting of concerns in the service we observed, that these supervision sessions were used appropriately to ensure that staff had a good understanding of their roles and responsibilities in the home. The general manager told us after our inspection that supervisions would be a priority for staff to ensure they engaged with the urgent programme of change which was required in the home to ensure they were fully compliant with all the necessary regulations.

The registered provider had a programme of training in place to provide staff with the skills to ensure they could meet the needs of people. However, a record of all staff training showed staff had not always completed or updated this training. For example, of 31 registered nurses and members of care staff; 19 had not received training on breakaway techniques which should be used if a person becomes aggressive towards them, 19 had not received training on the management of challenging behaviours where physical intervention is not used, 15 had not completed training on dementia awareness and 21 had not received training on the Mental Capacity Act 2005.

We were not assured the registered provider and registered manager had monitored the effectiveness of the training staff had received to ensure best practices had been embedded in the home and people received safe and effective care. For example, although all staff had received training on safe moving and handling practices, we observed these practices were not always followed. A high number of incidents of skin tears and bruises had been identified in the home when people were being supported to move. This provided further information that staff did not always follow safe moving and handling practices.

The lack of effective supervision and training for staff meant we were not assured people received care from staff who had the right skills and competencies to meet their needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some care plans showed people were able to access a wide variety of core and specialist external health care professionals. For example, referrals had been made on behalf of people to professionals such as Tissue Viability Nurses, dieticians and speech and language therapists. However, other people's care plans were so basic or non-existent it was not possible to verify this. Some care records did not clearly identify whether health care professionals had been involved when they were required.

For example, on 13 February 2018 the clinical manager told us they had requested a GP refer one person to the community health team for an urgent review of their mental health needs. They told us the GP had not yet done this and so they were chasing them to complete this. However, care records for this person clearly identified that a referral had been made by the GP on 11 January 2018 requesting support for this person. No contact had been made with the community mental health team by staff to follow this up, despite the deterioration in this person's mental health. The clinical manager told us they were not able to meet the needs of this person, however no assessment of these needs had been carried out and no external health care professional's opinion had been sought. For another person who had lost weight over a short period of time, this had not been identified to a GP for possible further review. For a third person who had fallen on many occasions in a short period of time this need had not been assessed and appropriate professional advice sought to ensure their safety and welfare.

Whilst support had been sought from external health care professionals for some people, we were not assured staff consistently approached other professionals to support people. This meant people did not always receive care and treatment that was safe and met their needs. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives we spoke with said the food provided at the home was good and there was a variety of foods available for people each day. One person said, "It's good." A relative told us, "Occasionally I have a meal here, it's always good." The menu was based on a five week rota, there was a choice of meals on offer and kitchen staff would prepare other food for people on request. There were usually two chefs on duty, offering a seven day a week service and they were aware of people's likes, dislikes and preferences as well as any special dietary requirements.

Meal times did not offer people a good dining experience. We were told people made their meal choices in the morning and that those with short term memory loss, such as people with dementia, could choose from presented plates of food at the dining table. This practice was not evident during our inspection. Staff delivered plated meals for people one at a time with some people who required support with their meals waiting for more than an hour after others to have their meal.

We spoke with the general manager about the dining experience people received and they told us they had observed some poor practices at this time and these would be addressed.

The kitchen was clean and well managed and the home had received a five star rating by the Food Standards Agency in September 2017.

Inadequate

Is the service caring?

Our findings

People and their relatives said staff were generally caring. One person told us, "It's highly satisfactory here. It's beautifully calm. There's no shouting or bad tempers. The staff are delightful." Another person told us, "I have always been received with great courtesy and kindness." Both people told us they would recommend the home to others. A relative told us, "[Person] is very happy and contented here. [Person] is always washed and shaven and their room is clean. [Person] seems to have a good relationship with some [staff]." A second relative told us, "I have no complaints whatsoever. They [staff] know the standards I expect." They told us they would recommend the home to others. However we found people were not always valued and respected as individuals.

At this inspection we observed care and support given to people throughout the three days. Interactions between people and some staff were respectful and kind. These staff showed a genuine warmth to people and consistently took care to ask their permission to support them, provided caring and respectful responses to people's needs.

However, many staff delivered care in a task orientated way where their need to complete the task was a higher priority than a person centred approach to the people who lived in the home. There was not a calm and inclusive atmosphere in the home, and large communal areas did not always have staff present to support people. Call alarms and bells were ringing constantly on the first two days of our inspection although this had improved on our third day; the impression was of a workplace rather than people's homes. We could not speak with many care staff on the first two days, despite efforts made on both afternoons as we were told they were too busy to spare time. On the third day of our visit staff were approachable and spoke freely with us. Those staff we did speak with thought the home was a caring place. One staff member told us, "I think the care is good and we are a good team". Another said, I think we provide great care here. We have people who came in for terminal care who are still here and have improved." However, our observations during our inspection did not support these views.

Staff frequently referred to people by their room number, even in their presence. For example, one person was being wheeled to a communal area and a staff member said, "I have done room [number] now I just have [room number] to do and I am done." Another member of staff was asked by a registered nurse to support a person who was distressed and they said, "I haven't finished [room number] yet." This showed a complete disrespect for the individuality of the people who were being cared for.

Some staff members did not treat people in a respectful and courteous manner and these interactions were not challenged by other staff. We saw several examples of people being treated in a way that was not appropriate or dignified. One person called out loudly whilst sitting in a communal area. Another person shouted at them, "Oh be quiet," and a member of staff said, "I am busy at the moment, what do you want." Both of these people were clearly agitated but staff did not take the time to address their concern and treat them with respect. On three separate occasions we heard one member of staff speak to people in a childlike way which was not respectful. Other staff did not challenge these interactions.

We observed staff placing clothes protectors around people's neck before mealtimes without interacting with them or asking permission before doing so; on one occasion a member of the inspection team was speaking with the person when this occurred. One member of staff removed cutlery from a person's hands and proceeded to cut up their meal without interacting with the person at all. When they had finished they handed a fork back to the person and pointed at the food and said, "Enjoy." The person looked at the member of staff and put their eyes to the ceiling. They did not appear to be happy with the way in which the member of staff had interacted with them. We observed staff walk past people's rooms, ignoring them when they were calling for help.

Whistleblowing concerns were raised during our inspection about the lack of respect shown by a member of staff to four separate people for whom they were providing personal care. The registered manager took immediate actions to address these concerns. However, we were not assured that staff were confident to address behaviours of other staff members which were not respectful and ensured their safety and welfare. There was an accepted culture in the home of staff 'doing to people' rather than staff 'supporting people' to do as they wished.

People's dignity and privacy was not always respected. For people who required a soft diet, we saw this was presented well on a plate. However, we observed staff mashing foods all together noisily and then giving food to people without interacting with them whilst they sat in a communal area. Other people who did not have their meals, or had already been given their meals by staff, sat watching each other. Staff did not offer people the opportunity to eat the meal in a more private or dignified way.

One person was sitting in a darkened corridor, wearing just a vest and underpants, they were clearly in distress. We observed this person for 15 minutes, during which time three members of care staff walked past them without offering assistance or even acknowledging their presence. A member of the inspection team felt it necessary to intervene and inform a registered nurse of the situation, and request the person was given support. The person did not have the capacity to understand why they were sitting in this place, in their underwear, without any help and were clearly distressed. Staff did not show respect for this person's privacy and dignity.

For a second person we observed them being wheeled in a wheelchair to a busy communal area of the home, next to a sofa. The person was speaking with the member of staff about their past however, the member of staff was clearly ignoring them and cut them off mid-sentence to say they would need to find another member of staff to help them. They then walked away from the person and did not return. This person was not treated in a dignified and respectful manner. A third person was sat for over two hours in a specialised chair behind another person. Their only view was of the back of another specialised chair. This meant they were unable to participate in any meaningful conversation or interaction with others and was not respectful of their needs.

Some staff moved people around the home without interacting with them in meaningful ways. For example, we observed one member of staff pull a person in their chair backwards towards a lift without any interactions with the person.

The lack of dignity and respect afforded to people by some staff was a breach of Regulation 10 of the Health and Social are Act 2008 (Regulated Activities) Regulations 2014.

People's rooms were personalised with their own furniture and belongings if they chose. We had received whistleblowing concerns which identified people were being 'kept in their rooms with the doors closed' if they sustained injuries following a fall or other incident. We checked all areas of the home and found that

people who remained in their rooms did so because of a clinical need or it was their choice to do so. One person told us, "I like to stay here, it's peaceful." People could access their rooms when they wanted to.

Care records showed no evidence that people or their representatives had regular and formal involvement in on-going care planning and risk assessment. Care plans and risk assessments were not discussed and agreed with people or their representatives. They were not reviewed regularly by staff and were not signed by people, relatives or representatives. Some people living at the home did not have any care plans at all.

Inadequate

Is the service responsive?

Our findings

People's care was not always responsive to their individual needs and staff were task orientated in their approach to people's care needs. Some staff appeared to know people well although did not always demonstrate how to meet people's needs in a person centred way.

For some people who had lived in the home for more than four months, we saw care plans held some personal and social histories and people's preferences and wishes were incorporated into their plans of care. For people who had come into the home in the four months before our inspection we found the information in relation to their specific needs was lacking in detail and had not been used to inform any plans of care. This meant there was not always clear information available for staff on how to meet people's needs. Care plans in place lacked information about how people should receive care in a way which was person centred and specific to their needs.

For some people, who lived with dementia, we saw their plans of care lacked information on how staff should assess each person's pain or agitation and actions they should take to support these people in a personalised way. There was no information for staff on how they could support people with behaviours which may have been distressing or caused harm to them or others. For example, for one person who had lived at the home since 20 December 2017 and could display agitated behaviours towards staff and other people, we found there were no plans of care in place to identify how staff could best support this person and ensure their safety and that of others. This person had received a large number of skin tears following personal care, when staff daily records showed the person could be aggressive and distressed. There was no personalised care planned for this person to meet their needs. They had been living in the home for two months.

We saw some people were not always supported in an individualised way to maintain their comfort or distress without the possible undue effects from taking medicines they may not have required. This was clearly demonstrated when one person was prescribed a medicine to be given as required before staff supported them with personal care, to reduce their anxieties. On three occasions over fourteen days this medicine had been given before the person was supported with personal care. There was no information as to why this was needed or why on other occasions this was not required. We were not assured people were being supported in an individualised and therapeutic way to ensure their pain and anxiety was manage appropriately.

The registered provider displayed some information about the home, how to make complaints and other documents such as menus in the home. However for people who lived with dementia they did not always have access to the information they needed in a way they could understand it and the home was not complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

The lack of personalised care people received which was not always responsive to their needs was a breach

of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

There was a lack of activities and meaningful interactions in the home to reduce the risk of social isolation for people. Whilst a planned list of activities was completed for each month, an activities coordinator was unable to provide us with a copy of the activities for the month of February 2018. They told us these activities should be displayed in people's rooms to let people know what activities were on. We asked about the activities they supported people to do and they told us, "I tend to do what I think I will get more response from." We were unable to see the planned activities for the day as they were not displayed in the home or people's rooms.

People were engaged in one to one activities with the activities coordinator at approximately 09:45am, reading a newspaper and interacting with others about the stories in this. However, the activities coordinator had to stop interactions with people at 10:20am when they said, "I've got to stop now as I've got to make the drinks. We can continue Saturday when I am back." The activities coordinator supported people with their meals at lunchtime and told us, "Yes, I fed three today and did all the teas and coffees this morning. I haven't stopped, but that takes you away from your role. We work as a team, so I help with what I can, drinks, taking people to the toilet." We asked the activities coordinator how they knew how to meet people's needs. They told us, "The girls [staff] tell me." We were not assured people's needs were always met in line with their needs and preferences. Staff did not provide stimulating and meaningful activities for people, particularly those who live with dementia.

We asked people if there were activities for them to enjoy. One person said, "I am not fully aware of what is going on. I think there was a trip out somewhere." Another told us, "I don't really know what there is."

For people whose care plans did contain information about their previous interests and occupations there was no guidance for staff on how to use it to better the person's quality of life. For example, one person had worked as a mechanic and had an interest in how mechanical items were made and how they worked. Though the person lived with dementia, this interest persisted. However, their behaviour support plan did not mention this. Their communication plan did, recommending that staff "can give me something to fiddle with". We noted this person was walking around the home on both days of our visit, touching objects and attempting to 'fix' them, for example, the lift and a plant arrangement. Their social interaction plan did not contain information for staff concerning ways of constructively harnessing the person's interests in a meaningful manner. We noted from a recent letter in the care plan that a model house had been provided for the person with locks and bolts on, but we did not see this item during our two day visit, nor was it visible in their room.

There were two planned activities on the third day of our inspection. A children's group visited the home in the morning to interact with people. However, activity staff took time to play with the children and there was minimal interaction of people with each other or the children. We noted from observing this session that the staff remained task oriented; staff presumed that people living at the home would want to be involved. However, the children's age group was very young for meaningful interaction and there was no acknowledgement that people may not have wished to be present or even enjoyed the presence of the children.

People were at risk of social isolation due to the lack of activities and meaningful interactions available to them. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The complaints policy was displayed in the entrance to the home. It contained information about how and

to whom people and representatives should make a formal complaint. There were also contact details for external agencies.

We looked at the provider's complaints log. There were two formal complaints contained within it covering the period from July 2017 to February 2018. Neither had been managed in a timely and satisfactory way. Actions had not been taken to fully investigate these complaints and ensure appropriate actions were taken to ensure the safety and welfare of people. Whilst policies and procedures were in place to deal with complaints, the registered provider and registered manager had failed to ensure these were followed.

This was a breach of Regulation16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

There had been recent significant changes to the leadership and management of the home.

At the time of our inspection a new registered manager had been in post since January 2018, although the previous registered manager (the clinical manager) had remained in the home to provide clinical leadership until this role was filled. 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.

On the first day of our inspection a new general manager had been in post for two weeks and told us they were planning to become the registered manager for the home. During our inspection we found there was a serious lack of guidance and leadership in the home to ensure all staff had a good understanding of their roles and responsibilities in maintaining the safety and welfare of people who lived in the home.

Whilst the registered manager and general manager demonstrated the skills to support staff and be an integral part of the daily staff team, they were unable to do this. Their roles were overwhelmed with the amount of change required in the systems and practices in the home, which they had recognised was needed, to ensure the safety and welfare of people.

Staff did not have clear guidance and support to understand and recognise their responsibilities in the home; there was a lack of structure and respect for others in the staff team. Staff appeared unclear on who they should provide information to in the event they had any concerns. Most staff approached the clinical manager readily to look for support and ask for guidance because the new registered manager and general manager had not yet established their roles in the home. The clinical manager, who had worked at the home for over five years, left the home on the second day of our inspection. On the third day of our inspection, the general manager was on leave and we saw staff did approach the registered manager for support, however there was a lack of visible leadership and support 'on the floor' in the home.

Registered nurses did not appear to have the authority or autonomy to address concerns consistently or appropriately. For example, poor moving and handling practices went unchallenged by registered nurses who were not visible on the floor of the home during busy times such as meal times and during morning personal care support. When one registered nurse requested a member of care staff support a vulnerable person they were given clear information that they could not help as they were busy. The registered nurse did to take action to prioritise the care this person required.
On the second day of our inspection, we asked the registered manager and general manager if we could speak with care staff about their experiences in the home and to gain their views on their role. We were told the care staff had responded that they were, "Too busy" to speak with us. The general manager told us they had requested staff move from an area during a meal time and support staff in delivering meals for people. Staff told them they did not wish to do this as, "CQC were watching them, "and, "Who do they (CQC inspection team) think they are?" There was a very poor staff led culture which had not been addressed by

senior managers. This poor culture and lack of leadership in the home meant we were not assured people received the care they required in a way which was in line with their needs and preferences. Staff were more open to communicate with the inspection team on the third day of our inspection.

We spoke with the registered providers at the end of our second day of inspection. They told us they recognised the need to review and establish a strong leadership team and change the apparent poor staff culture in the home and that this would be addressed immediately. We saw some actions had been taken to change this structure on our third day of inspection; however these actions were not sufficient to assure us people were safe in the home. The nominated individual for the registered provider put in place a clear structure of support for staff to ensure they were providing safe and effective care for people before we left the inspection. Following our inspection the registered provider identified how they would work closely with the local authority and commissioning groups to ensure the safety and welfare prioritise actions in the home to be compliant with all of the fundamental standards set out by law.
On 17 and 23 January 2018 we shared a whistle-blower's concerns with the local authority and we asked the registered manager of Westacre Nursing Home to investigate these concerns. The completed investigation failed to identify any serious concerns in the home. However, during our inspection we found the whistle-blower's concerns to be an accurate reflection of the care being delivered at the home. The investigation into these concerns was not robust or open and transparent.

Care records were not always available, accurate, consistent or up to date. We observed occasions where records were not stored securely on the first floor of the home. We were particularly concerned that the high number of agency staff working in the home did not have access to up to date records on people's needs and preferences, especially as some of these staff administered medicines for people. We received concerns from a whistle-blower during our inspection about the lack of records available for new staff to gain an understanding of people's needs. The general manager told us this would be addressed immediately and some actions had been taken to address this before the end of our inspection.

Whilst the registered provider had ensured accurate and up to date audits of the health and safety in the home, maintenance and equipment were completed, there was a lack of robust and effective audits in the home to identify the concerns we had raised during our inspection. For example, incidents and accidents were reviewed monthly. However, these were merely a description of the incident such as a fall, skin tear or bruise and there was no evidence of the provider attempting to identify causality or common themes emerging. Care records had been reviewed however prompt actions were not taken to address the concerns these identified. For example, three care records we looked at had been audited on 31 January 2018 and several areas in each care record required updating or additional information completing. These had not been done. Three records we looked at lacked any information about people's care needs and this had not been identified. The registered provider did not have efficient systems in place to identify the poor staff practices which were evident in the home such as moving and handling and communication.

An independent care consultant had completed audits of the home to provide information on areas in need of review. These had been completed in December 2017 and January 2018 and showed significant areas of improvement were required in the home. These had yet to be addressed.

The registered providers, registered manager and general manager acknowledged there was a large amount of work required to ensure staff understood their roles and responsibilities in the home and that people received safe and effective care in line with their needs and preferences.

The registered provider had formally sought the opinions of people using the service in March 2017. We noted satisfaction surveys were given to people and their relatives to complete and return. We looked at

twelve of these which had been completed and returned. Whilst the questionnaires showed a high degree of satisfaction in some areas, such as food quality and cleanliness, six expressed a degree of dissatisfaction at the lack of activities at the home and two felt there were not always sufficient staff available to meet their needs. Our own observations and conversations indicated these areas remained problematic. This demonstrated that appropriate action had not been taken based on people's feedback.

The lack of consistent and effective leadership, poor record keeping and poor governance in the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider is legally required to notify the Care Quality Commission (CQC) of any serious incidents or allegations of abuse which occur in the home. We found they had failed to do this. Incidents of alleged abuse which had occurred in the home had not been reported to us.

This was a breach of Regulation 18 of the Care Quality Commission Regulations 2009.