L Downing

Westcotes Rest Home

Inspection report

113 -115 Hinckley Road
Westcotes
Leicester
Leicestershire
LE3 0TF

Tel: 01162332919
Website: www.westcotes.co.uk

Date of inspection visit:
17 July 2018
18 July 2018

Date of publication:
15 August 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Westcotes Rest Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulated both the premises and the care provided, and both were looked at during this inspection.

Westcotes accommodates 20 older people, some people are living with dementia in one adapted building. At the time of the inspection there were 14 people using the service. The accommodation is provided over three floors with a passenger lift for access.

There is no requirement for a registered manager to be in post at this service as the owner is a sole provider. The provider has the legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The inspection was prompted by information of concern received by the Care Quality Commission about the service. This inspection has focused on these areas of concern, which included staff recruitment, medicine management, supplies of food and drink, cleanliness and maintenance of the service.

We found significant shortfalls in the prevention and management of infection control. Systems to identify potential infections risks to people were neither comprehensive or robust. Many soft furnishings within the premises, which included armchairs and carpets, were heavily stained and malodorous. Damage to kitchen cupboards, paintwork, bathing and toileting facilities, which included broken tiles, meant surfaces could not be effectively cleaned.

People's safety was compromised as information held within their records, which included risk assessments and care plans, contained conflicting information. This meant there was potential for people not to receive consistent and safe care. People's records had been reviewed, however the review process was not robust as it had failed to identify inconsistencies. Information identifying how people's safety was to be promoted was not supported by clear guidelines and protocols. This included what action to take in an emergency and the use of medicine that was prescribed to be taken as and when required.

People were supported by staff who had undergone the appropriate checks prior to commencing their employment. There were a number of staff vacancies, which meant existing staff were working additional hours. This had an impact on other services, which included the day to day management of the service and cleaning, as staff employed in these roles were instead providing personal care and support.

The provider did not have systems and processes to assure themselves about the quality of the service being provided. This lack of oversight and ineffective governance meant the premises, fixtures and fittings being in a poor standard of repair.

The provider's policies, which had been reviewed, contained inaccurate information and were not

consistently put into action or followed. This had a direct impact on people using the service, as people lived in a property that was not well maintained, putting them at risk of harm. Opportunities to develop the service were missed as people using the service and family members were not consulted on an annual basis as set out in the provider's policy. Where people's views were sought in meetings, there comments had not been acted upon.

People we spoke with and a family member spoke positively about the care and support provided by staff.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The premises' furnishings were not kept clean and hygienic which put people at greater risk of infection.

People's records contained inconsistent information, which meant there was potential risk of people not receiving their care and support safely.

Improvements were needed to ensure people who were prescribed medicine to be taken as and when required had clear guidance for staff. To ensure medicine was safely administered as per the prescribers' instructions.

People were safeguarded from abuse as staff were aware of their responsibilities in alerting relevant agencies with any concerns.

Is the service well-led?

Inadequate

The service is not well-led.

The provider had not kept under review the day to day running of the service, to assure themselves that people using the service resided in an environment that was clean, free from offensive odours and was maintained and equipped to meet their needs.

The provider did not have systems in place as to the governance of the service. There were no reliable and effective systems to assure people's views were sought or opportunities given to influence the service they received.

Westcotes Rest 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 checked 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.

The inspection was prompted by information of concern received by the Care Quality Commission received about the service. This inspection has focused on these areas of concern, which included staff recruitment, medicine management, supplies of food and drink, cleanliness and maintenance of the service.

The inspection was carried out by one inspector

The inspection site visit took place on 17 July 2018. We returned to Westcotes Rest Home on 18 July 2018 to complete the inspection.

We contacted commissioners requesting feedback about the service.

We looked at the information held about the provider and the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us. We used this information to help us plan this inspection.

We spoke with three people and spent time with others who used the service. We spoke with a family member who was visiting their relative. We spoke with the manager, three support staff and the maintenance person.

We looked at the care plans and records of two people. We looked at a selection of medicine records. We looked at the recruitment records of three staff. We looked at the minutes of meetings for staff. We looked at records which sought people's views about the service. We viewed records of the maintenance of the environment and equipment, along with quality monitoring audits.

Requires Improvement

Is the service safe?

Our findings

We found significant shortfalls in the prevention and control of infection. Weekly infection control audits were not comprehensive and had a very limited scope. This meant shortfalls had not been identified. The manager informed us that the issues we had identified had been brought to the attention of the registered person over a prolonged period of time. However, no action had been taken by the provider.

Armchairs in communal areas, and in some bedrooms, were heavily stained and malodorous, with dirt and urine. A majority of the armchairs had permeable fabric coverings, which meant leakages and dirt was embedded deep into the furniture. Carpets in communal areas and bedrooms were stained, with some being malodourous. Kitchen cupboards were broken, the ceiling was stained and there was significant dust by the refrigerator, which was leaking. Skirting boards and architrave was damaged throughout the premises with flaking paint and in some places peeling wall coverings.

We found some bathing and toilet facilities were in a poor standard of repair. One shower was not in use; the shower chair attached to the wall on the shower base was broken due to rust. One toilet, which was raised on a pedestal and had a tiled surface, had broken tiles and was heavily stained. Flooring in some toilet areas was stained.

On the day of the inspection the maintenance person had cleaned the carpets in the communal areas of the premises. However, this had not removed all the stains.

In the rear courtyard there was an area that was screened by wooden fencing. We found a significant pile of black bin liners containing rubbish, along with a yellow bin liner, which contained clinical waste. The manager informed us there were insufficient bins to store the rubbish, which meant there was an overflow of waste. The manager informed us the registered person had been informed of this issue. However, no action had been taken. During our inspection we saw a person, who used the service, looking through the waste. This meant they were at risk of contracting an infection. We brought this to the attention of a member of staff, who redirected the person.

These are breaches of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Premises and equipment.

The provider engaged external contractors to maintain and service equipment, which included electrical and gas systems, the fire system, the passenger lift and equipment used to support people in the delivery of their personal care, such as hoists and other mobility aids. All systems had a certificate to evidence they had been assessed as safe at the time of the inspection.

Information recorded within people's risk assessments and the action to be taken by staff to reduce potential risks was not consistent. We found information in people's care plans contradicted the information within their risk assessments. This had the potential for people not to receive the care and support needed. For example, a person's care plan for food and fluids stated they preferred a diet of

sandwiches rather than having hot meals and they enjoyed eating crisps and preferred cold drinks. The person's risk assessment for aspiration (choking) and SALT (speech and language therapist) said that following a hospital admission, a SALT had assessed the person and found they needed a pre-mashed diet and slightly thickened fluids. The same person had a risk assessment for the management of their diabetes. However, the person's care plan for food and fluid made no reference to the person being diabetic and therefore no dietary requirements were recorded to manage the person's health condition. Both the care plan and the risk assessments had been reviewed in June 2018 and recorded no change, which showed the review process was not robust or effective. We spoke with the manager who told us that the risk assessment was not accurate as the person was no longer at risk of choking and ate a normal diet. The manager confirmed they would update the person's records to ensure they were accurate.

A second person's risk assessment identified they were at risk of developing pressure sores. The action to reduce the risk was the use of pressure reliving equipment, which included a specialist mattress and a profiling bed. The risk assessment detailed the type of mattress and how it was to be used. We checked the mattress was being used consistent with the risk assessment. The senior support worker told us the person no longer had the identified mattress as it was no longer required. This was a further example of information held within a person's records not being accurate. The risk assessment had been reviewed in June 2018 and recorded no change. This shows that the reviewing of people's records is not effective. The manager confirmed they would update the person's records to ensure they were accurate.

Individual personal emergency evacuation plans (PEEPS) were in place, which provided guidance on the support people would require should they need to evacuate the service in an emergency. However, these did not detail the level of risk. One person's PEEP had not been updated to reflect they had moved to a different bedroom. The manager said they would review the person's PEEP and look at a comprehensive tool to assess individual risk.

These are breaches of Regulation 12 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

The manager and other staff informed us a number of staff, including the deputy manager, had recently terminated their employment, which meant staff were working additional hours to ensure people received the care and support they required.

On the first day of our inspection visit, there were sufficient staff on duty in the morning to meet people needs, which included a staff member employed to cook the lunchtime meal and to clean the premises. In the afternoon, there were three care staff on duty. A person had a hospital appointment and a member of staff accompanied them. No additional staffing arrangements to cover this reduction in staff numbers had been made in advance. The senior support worker contacted a member of staff and requested they work additional hours, until the other member of staff returned. The member of staff returned to work to provide care and support to people.

On the second day of our inspection visit, there were sufficient staff on duty in the morning to meet people's needs. However, the member of staff employed to cook the lunchtime meal and to clean the premises, due to staff shortages, was providing personal care and support, for which they had the appropriate training. This meant that the cooking of the lunchtime meal was undertaken by the same staff who were providing care, which meant there was less support available for people.

We asked the manager how they determined the number of staff required to meet people's needs safely. They told us staffing levels were determined by the registered person. The manager said they were advised

by the registered person that people's needs could be met by three members of support staff on duty throughout the day, and two staff during the night.

We found however, that a member of staff employed to cook and clean the premises, was often used to provide care and support. The manager informed us that in some instances they provided care and support, which prevented them carrying out management duties. The manager informed us that the registered person was aware of the staffing situation and they had advertised the vacant positions. The staffing rota did not distinguish in what capacity a member of staff was working, for example, whether they were rostered to clean and cook or to provide care, which meant it was difficult to determine whether there were sufficient staff to meet people's needs. The manager told us they would make changes to make this clear on the staff rota.

People's safety was supported by the provider's recruitment practices. We looked at recruitment records for some staff. Prior to being employed, all new staff had an enhanced Disclosure and Barring Service (DBS) check, two valid references and health screening. (A DBS is carried out on an individual to find out if they have a criminal record which may impact on the safety of those using the service).

We found that people's medicine care plans detailed the medicine they were prescribed, consistent with the medicine administration records (MARs). The medicine system showed that people had been given their medicine. People's records had been updated to reflect this, with staff signing to confirm they had administered a person's medicine.

People who were prescribed PRN (medicine to be given as and when required) did not always have a protocol in place to provide clear guidance as to how and in what circumstances the medicine was to be administered. The manager informed us that a recent visit carried out by staff of Leicester City contract and assurance service had identified this issue. As a result, people's doctors were being contacted so the protocols could be put into place. The senior support worker administering medicine had, in their staff file, an assessment as to their competence to administer medicine, which provided assurance people were safely provided with their medicine.

People we spoke with told us they felt safe at Westcotes. One person said, "I do feel safe, I don't know why, I just do."

The staff we spoke with understood their safeguarding responsibilities. They were aware of the signs of abuse and who to report these to. Records showed there had been no safeguarding incidents since our last inspection. The manager and staff were aware of how to raise safeguarding concerns, which included contacting the local authority and the Care Quality Commission (CQC).

Records showed accident and incidents were recorded and the appropriate agencies, including the CQC, were notified. We asked the manager how they responded to relevant external safety alerts from external agencies. They told us as far as they were aware all such alerts would be sent to the registered person; no alerts had been forwarded to the manager from the registered person. This was of concern because people may not have been protected from known risks to their safety.

Inadequate

Is the service well-led?

Our findings

There is no requirement for a registered manager to be in post at this service as the owner is a sole provider. The provider has the legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run. We found limited evidence to support the providers' acknowledgement of their responsibility and accountability.

The provider had appointed a manager. The manager told us they had been in post for 18 months. The manager and staff told us the registered person had not visited the service for a period in excess of two years. The manager said they had regular contact with the provider, by visiting them in their own home or by telephone; and until recently by e-mail, however the service's computer had broken. The manager and staff said they had spoken with the provider and raised their concerns about the condition of the premises. However minimal action had been taken by the provider.

The lack of oversight by the provider meant there were significant shortfalls in the maintenance of the premises, both internal and external to the service, which included fixtures and fittings. We found the external paintwork to windows to be peeling, we identified damage to a roof tile on a bay window to the front of the property. The external wood frame of the kitchen window was rotten. The courtyard to the rear and sides of the property, included plastic furniture and a table for people to sit, these were broken and damaged. Pots to grow plants at the front and rear of the premises, were mostly filled with weeds or dead plants. In the rear courtyard was an area partitioned with wood fencing, and was used as an over flow area to store rubbish due to insufficient bins. We were informed by the maintenance person and staff they had on occasions paid to have the rubbish cleared themselves for the benefit of people using the service.

Internally we found stained carpets and armchairs, and broken and out of order bathing and toilet facilities. The kitchen had a stained and damaged ceiling, broken cupboards and a refrigerator that was leaking. There was general damage to interior fixtures, which included dining tables and chairs, and bedroom storage furniture.

At the time of the inspection there were no bathing facilities that were working, and only one shower was working at Westcotes Rest Home. The showering facility was not large enough or appropriate to use where a person required the use of equipment, such as a hoist. This meant some people using the service did not have the opportunity to have a bath or shower and were restricted to body washes.

We spoke with a family member who was visiting their relative. They told us they had made a complaint to the manager about the stained carpet in their relative's bedroom. They showed us a sheet that had been laundered and placed in their relative's room for later use. The sheet was heavily stained. They told us that the day before another bed sheet they had found was in much worse condition. The manager told us new sheets had been ordered that day following the complaint from the family member. The manager stated they would be requesting staff to look at all the sheets and towels and to dispose of those not fit for purpose. The manager had arranged for a new carpet to be fitted in the person's bedroom for the following week.

On the second day of our inspection visit, the maintenance person was cleaning carpets in communal areas on the ground floor. They told us their agreement with the registered person was to provide two hours of maintenance a week.

We found examples of staff's commitment to caring to people who use the service. For example, we noted on both days of the inspection two people had to attend hospital appointments. On both occasions a taxi was booked and they were accompanied by a member of staff. The manager and staff did not have access to a contingency fund to pay for the taxi, but instead paid themselves, with a view to claiming back the expenses.

We found policies and procedures had been reviewed but not signed by the registered person in November 2017. The manager said all policies and procedures were provided by the registered person. We found, whilst the policies and procedures had been reviewed the contents did not reflect current legislation and were either not fully implemented or not applicable to Westcotes Rest Home. For example, the infection control policy stated all yellow clinical waste bags should be 'stored safely away from service users and visitors'. Our observations found this was not accurate as we saw a person using the service looking through the refuse. The heatwave policy included, 'check that the air conditioning system is service regularly and in good working order'. Westcotes Rest Home does not have an air conditioning system.

Meetings involving people who used the service, referred to as 'resident meetings', had been recently held. People had expressed their wishes with regards to day trips to a range of locations. The minutes recorded their suggestions, which included local parks and facilities as well as seaside locations. Other activities suggested, included a summer party, a barbeque and karaoke. We found no action had been taken to organise the activities as suggested by people.

The provider's policy for quality monitoring of the service, referred to the service people should expect, to be of the highest quality-care and accommodation possible and to be given a say in the running of the home. The policy stated that people's and relative's views would be sought through meetings and annual surveys. Meetings involving people had been held, but their views about activities had not been actioned.

The most recent surveys were dated 2016. The policy refers to an 'annual development plan', that is fully costed, that identified specific and measurable goals with the actions and resources allocated to achieve them. The policy went on to state that plans will be rigorously monitored and reviewed. We asked the manager for the 'annual development plan'. They told us they had no knowledge of such a plan, even though the policy had been reviewed as being accurate in May 2016.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

Staff records, included staff supervisions and identified topics discussed, which included employment issues such as a holiday and sickness, keyworker responsibilities related to keeping people's bedrooms clean, training and fire safety. Annual appraisals were linked to staff attendance and work performance. Staff meetings, supervisions and appraisals were not used as an opportunity to drive improvement, share ideas or used to inform staff about best practice guidance with a view to providing high quality care. We highlighted to the manager good practice guidance was available and where it could be sourced.

The manager acknowledged improvements were needed and spoke of their commitment to bring about change. However, they said their ability to bring about the improvements required would be difficult as they explained that for two days out of the five they worked was spent with the registered person at their private

residence to process staff payroll. In addition, the deputy manager had recently resigned and had not been replaced. Also, because of staff shortages the manager had to directly provided personal care. All of this impacted on their ability to effectively manage the service.

The manager informed us that external stakeholders, including Leicester City contract and assurance service, had recently visited and were in the process of providing action plans for the provider to bring about improvement.

People we spoke with, including a family member, spoke positively about the personal care and support people received. One person told us, "They (staff) look after you very well, I can't grumble." They went onto share their views about the meals, "Food is good. If anybody moans about the food they must be dam fussy." A second person told us, "The staff are very nice, couldn't be nicer, even get a kiss as soon as they come in, in such a family friendly way. The staff are always here for you, never had words with anybody." This showed that even under difficult circumstances, staff had provided a caring and friendly atmosphere to people.

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 The provider had failed to ensure the safe care and treatment of people. Risk assessments providing guidance and information, were contradictory or had omitted information to that detailed within their care plans.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure the premises and equipment were clean, suitable for the purpose for which they are being used and properly maintained. Includes but does not necessarily exclude other areas for improvement. Inadequate bathing and shower facilities to meet the number and needs of people using the service. Bathing, shower and toilet facilities were not maintained. Furnishings, including carpets and comfortable seating, were stained and malodourous. Furnishings including bedroom and dining furniture were not in a good state of repair. External space for which people using the service had access too were not maintained and did not provide a safe and comfortable space to relax. The external of the premises was not well maintained, with peeling paint, rotten window frames and sills.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems and processes to make sure they assessed and monitored the service. Systems and processes to monitor the quality of the service being provided were not implemented. Audits used were ineffective and did not trigger improvement. Policies were not an accurate reflection of the service and were not implemented and did not reflect up to date legislation or guidance to ensure quality and safety standards were maintained. Opportunities for the views of people using the service, family members and stakeholders to comment and influence the service provided were limited and people's views when sought were not acted upon.

The enforcement action we took:

Warning Notice